The Center
for Integrative Counseling
and Psychology

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

The person/organization that receives protected health information from The Center is prohibited by law from making further disclosures of it without a separate written authorization from you. The Center is not accountable for disclosure made by third parties who re-disclose information without your authorization.

CLIENT INFORMATION:

CLIENT NAME: _____ CLIENT DATE OF BIRTH: _____

CLIENT ADDRESS: STREET: _____ APT. #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE CONTACT #: DAY: _____ EVENING: _____

PERMISSION TO SHARE:	☐ I am requesting a copy of my/my child's paper file. (Skip to signature on back.) ☐ I give The Center permission to share protected health information with the party indicated below. ☐ I give permission for The Center and the party indicated below to communicate as necessary.

PARTY TO SHARE INFORMATION WITH:

Name: _____

Address:_____

City: _____ ST: _____ Zip: _____

Telephone Number: _____

Fax Number: _____

Send by:
☐ Mail
☐ Email
☐ FAX
☐ Pick-up at PCC office
☐ Phone contact

Purpose: (check the appropriate box)
☐ Medical Care
☐ Insurance
☐ Legal Matter
☐ Personal
☐ School Records request
☐ Other (please specify) _____

Processing fees will apply. (See details on following page.)

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PURPOSE OF USE OR DISCLOSURE Only the following purpose(s). Client must initial each reason for use or disclosure:

_____ To verify whether I am participating in and cooperating with treatment *(Former referral)*
_____ To allow the clinically appropriate management and coordination of my mental health and/or substance abuse treatment
_____ Psychological evaluation
_____ Continuity of my care
_____ Billing
_____ At my request
_____ Other (specify) _____
_____
_____

INFORMATION TO BE RELEASED Only the following information (Client must initial each item to be disclosed):

_____ All information
_____ Billing information
_____ Participation in and cooperation with treatment
_____ Diagnosis/Assessment and intake information
_____ Progress report on my counseling\ therapy notes
_____ Drug/alcohol history
_____ Discharge summary/ treatment recommendations
_____ HIV test results and/or HIV treatment information
_____ Other (describe) _____
_____

RECORD FEES:

There will be an administrative printing/faxing charge of $25 for the first 20 pages and $.50 per page for every print thereafter for client records. Additional fees may include costs for record mailing, shipping or delivery. Please note it will take 7 – 10 business days for processing records. Charges for client records must be paid in advance, and will be charged to the credit card on file.

AGREEMENT:

I understand that this authorization is voluntary, and I may revoke this authorization in writing at any time, except to the extent that The Center has relied on this authorization. The written revocation should be addressed to the letterhead address. Unless otherwise revoked, I understand this authorization expires one (1) year from the date of signature. A copy of this authorization is considered as valid as the original. I understand that The Center has no responsibility for disclosures made by 3rd parties once the information is released by The Center and the released information may be redisclosed and may no longer be protected by federal and state privacy regulations.

Form must be read and completed before signing. If you have any questions about this form, call 214-526-4525.

_____ OR _____
(Client's printed name) (Authorized representative's printed name)

_____ OR _____
(Signature of Client) (Date) (Signature of Authorized representative's if required) (Date)

If signed by authorized representative, describe authority to act for member:
☐ Parent ☐ Guardian ☐ Legal Authority _____

_____
(Signature of Witness) (Date)