



**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:	<input type="checkbox"/> I am requesting a copy of my/my child's paper file. (Skip to signature on back.)
	<input type="checkbox"/> I give The Center permission to share protected health information with the party indicated below.
	<input type="checkbox"/> I give permission for The Center and the party indicated below to communicate as necessary.

PARTY TO SHARE INFORMATION WITH:	
Name: _____	Send by:
Address: _____	<input type="checkbox"/> Mail
City: _____ ST: _____ Zip: _____	<input type="checkbox"/> Email
_____	<input type="checkbox"/> FAX
Telephone Number: _____	<input type="checkbox"/> Pick-up at PCC office
Fax Number: _____	<input type="checkbox"/> Phone contact
	Purpose: (check the appropriate box)
	<input type="checkbox"/> Medical Care
	<input type="checkbox"/> School
	<input type="checkbox"/> Insurance
	<input type="checkbox"/> Records request
	<input type="checkbox"/> Legal Matter
	<input type="checkbox"/> Other (please specify) _____
	<input type="checkbox"/> Personal

Processing fees will apply. (See details below.)



The Center
for Integrative Counseling
and Psychology

PURPOSE OF USE OR DISCLOSURE Only the following purpose(s). Client must initial each reason for use or disclosure:	
<input type="checkbox"/> To verify whether I am participating in and cooperating with treatment (<i>Former referral</i>)	<input type="checkbox"/> Continuity of my care
<input type="checkbox"/> To allow the clinically appropriate management and coordination of my mental health and/or substance abuse treatment	<input type="checkbox"/> Billing
<input type="checkbox"/> Psychological evaluation	<input type="checkbox"/> At my request
	<input type="checkbox"/> Other (specify) _____

INFORMATION TO BE RELEASED Only the following information (Client must initial each item to be disclosed):	
<input type="checkbox"/> All information	<input type="checkbox"/> Drug/alcohol history
<input type="checkbox"/> Billing information	<input type="checkbox"/> Discharge summary/ treatment recommendations
<input type="checkbox"/> Participation in and cooperation with treatment	<input type="checkbox"/> HIV test results and/or HIV treatment information
<input type="checkbox"/> Diagnosis/Assessment and intake information	<input type="checkbox"/> Other (describe) _____
<input type="checkbox"/> Progress report on my counseling\ therapy notes	_____

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 questions about anything on 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)



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If signed by authorized representative, describe authority to act for member:

Parent Guardian Legal Authority _____

(Signature of Witness)

(Date)