Authorization to Disclose Protected Health Information (PHI)

(Federal HIPAA regulations require that you are provided a copy of this form. Photocopy/ facsimile copy may be used as an original)

Client Information:

Name: _____ AKA: _____

Last 4 digits of Soc. Sec#: _____ Date of Birth: ___/___/___ ~~ASF#~~: _____

I, the undersigned, hereby authorize the ☐ Disclosure ☐ Exchange ☐ Request …of the following PHI.

PHI (Protected Health Information) from:	**Disclose PHI to:**
_____ Person/Agency	_____ Person/Agency
_____ Street Address	_____ Street Address
_____ City, State Zip	_____ City, State Zip
_____ Phone Number	_____ Phone Number

An authorization to disclose PHI is voluntary. Treatment, payment or eligibility for benefits will not be affected if you do not sign this authorization. Re-disclosure of PHI is prohibited without the specific written authorization of that person or as otherwise permitted by state or federal law. Information disclosed pursuant to this authorization may be disclosed by the recipient and no longer protected by state or federal law.

PHI TO BE DISCLOSED: (Client or representative must initial. Please check all that apply).

Initials

_____ ☐**MEDICAL RECORDS/PHI:** Specific Record(s)/Info:_____

_____ ☐**PSYCHIATRIC/MENTAL HEALTH** Specific Record(s)/Info:_____

_____ ☐**SUBSTANCE ABUSE TREATMENT PHI:** Specific Record(s)/Info:_____

_____ ☐**HIV RESULTS/Verification of Diagnosis:** Specific Record(s)/Info:_____

PURPOSE OF THE DISCLOSURE OF PHI: Specific Record(s)/Info: _____

(e.g., At the request of the individual, client review, continuity of care)

THIS AUTHORIZATION SHALL BECOME VALID IMMEDIATELY AND SHALL REMAIN IN EFFECT FOR THE FOLLOWING PERIOD:

You may revoke or modify this authorization to disclose PHI in writing at any time. However the information may have already been disclosed on the basis of this authorization.

(You must initial one of the following for the authorization to become valid)

_____ *Initials* This Authorization expires as specified (may not be longer than five years from signature date below) **Date of Expiration:** _____

_____ *Initials* This Authorization is in effect for **five** years from the signature date below.

TODAY'S DATE: _____ Client/Guardian Signature: _____

PRINTED NAME OF CLIENT/GUARDIAN: _____

RELATIONSHIP: *Choose One:* ☐ Client (Patient) ☐ Parent ☐ Guardian ☐ Representative ☐ Conservator ☐ Other: _____

Signer's Address: _____ Phone: _____

Witness Signature: _____ Printed name of Witness: _____