|  |
| --- |
|  |

**AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Please complete this form for each person you would like us to release your information to such as: Therapist, Primary Doctor, Family.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **I understand the advantages/disadvantages and freely and voluntarily give permission to release information about me.** | | | | |
| Patient Name  (Last, First MI) | | | | Date of  Birth |
| Social Security Number | | | | Date of  Consent |
| Information will be disclosed to and/or exchanged with **Judy L. Gonnerman, MA, LPN, LIMHP, LPC** and | | | Reason for Disclosure:  Request of patient  Obtaining past treatment records  Collaboration of care  Legal purposes  Consultation and/or treatment  Other (specify): | |
| Name | | |
| Address | | |
| City | State | Zip Code |
| Tel # | Fax # | |
| Specific information to be disclosed:  All records  Phone contact  Psychiatric Assessment & Update  Treatment Plan & Update  Psychosocial Assessment & Update  Psychological Evaluation | | | Physician’s Orders  Substance Use Assessment  Medication Administration Record  History & Physical Examination  Laboratory (X-ray, EKG, EEG)  Discharge Summary  Other: | |
| |  |  | | --- | --- | | Patient Signature | Date | | Personal Representative Signature  (Parent Guardian PoA) | Date | | Witness Signature | Date |   This Authorization (unless revoked earlier in writing) shall terminate 90 days from date of discharge or one year from date of signature, whichever is the latter. By signing this Authorization, I acknowledge that the information to be released MAY INCLUDE material that is protected by Federal Law and may be applicable to Drug/Alcohol related information. My signature authorizes release of all such information. I also understand this Authorization may be revoked at any time by submitting a written request and it will be honored with exception of information that has already been released. I also understand that, if the person/organization authorized to receive my information is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulation. | | | | |