**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.**

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| **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 **Kylee Stuart, LCSW** 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: |
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| --- | --- |
| 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. |