Authorization for Use or Disclosure
of Protected Health Information Client Information

Last Name: _______________ First Name: ________
DOB: ____________ Phone: _____________

Recipient Information

I, ___________________________, do hereby authorize Gina Watson, LICSW to release a copy of mental health information to the person or facility below.

Name of person/facility to receive medical information:

Information to be Released (Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)
__Entire mental health record
__Entire Substance Abuse Record (assessment, recommendations, urine drug screens)
__Initial Evaluation
__Substance Abuse Evaluation
__Verbal Communication
__Financial Information/Insurance/Billing
__Program Participation
__Discharge Summary
__Treatment Summary
__Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)
__Other____

Purpose of Information Release:
__Further mental health care
__Applying for insurance
__At the request of the individual
__Payment of insurance claim
__Legal investigation
__Coordination of Care
__Other (specify): _______________________________________

Authorization and Signature This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1966 (P.L. 104-191), 42 U.S.C. Section 132d, et Seq., and regulation promulgated there under, as amended from

time to time (collectively referred to as HIPAA"). This authorization affects your rights in the privacy of your personal behavioral health information. Please read it carefully before signing. I understand that the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Gina Watson, LICSW will not condition treatment on your providing authorization for the requested use or disclosure. You may refuse to sign this authorization. You have the right to revoke this authorization, in writing, at any time, except to the extent that Gina Watson, LICSW has taken action in reliance on it. By signing this authorization, I acknowledge and agree that any information used or disclosed pursuant could be at risk of re-disclosure by the recipient and no longer protected under HIPAA.
This authorization will expire on ___________________ (date). If I fail to specify expiration date this authorization will expire one year from the date on which it was signed. This information has been disclosed to you from record protected by 42 CR Part 2. The Federal Rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFT Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

____
Signature

Date ___________________

If signed by a personal representative: (a) Print your name:
____
(b) Indicate your relationship to the client and/or reason and legal authority for signing:
Patient is:__minor __incompetent__disabled __deceased
Legal authority: __parent __legal guardian __representative of deceased