AUTHORIZATION FOR RELEASE AND/OR RECEIPT OF PROTECTED HEALTH INFORMATION (PHI)

Last Name: _____ Fist Name: _____ Middle Initial: _____

Date of Birth: Month: _____ Day: _____ Year: _____ Social Security #: _____

Legal Guardian's Last Name: _____ Legal Guardian's First Name: _____

Phone number: _____ Fax number and/or E-mail: _____

I hereby authorize the use and/or disclose of my individually identifiable health information as indicated below. I understand that this authorization is voluntary and that if the entities authorized to share the information are not health plans or health providers, then the shared information may not longer be protected by federal privacy regulations.

Entity or individual **sending** information:	Entity or individual **receiving** information:
Name: _____	Name: _____
Street Address: _____	Street Address: _____
City: _____ State: _____ Zip code: _____	City: _____ State: _____ Zip code: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

INFORMATION TO BE DISCLOSED (*Check the appropriate lines and include other information where indicated*):

___ Neuropsychological/ Psychological evaluations and/or consultations
___ Comprehensive Medical Record
___ Summary Health Information: (includes Discharge Summaries, History and Physical, radiology, Pathology, Laboratory, Nursing and Operative reports/dictated notes)
___ Demographics and History
___ Clinical Therapy evaluations and progress notes/reports (Occupational, Speech and/or Physical Therapies)
___ Information relating to psychiatric and/or psychological diagnosis symptoms, prognosis, and treatment
___ Information related to treatment of alcohol and/or drug abuse
___ Other: _____

THE INFORMATION TO BE DISCLOSED WILL BE USED FOR THE FOLLOWING PURPOSE:

___ Sharing with health care providers
___ Insurance use
___ Legal use
___ Family members, friends, etc.
___ Other: _____

I request that the following information not be shared: _____

I understand and agree to the following (Please read and initial the statement below):

___ I have the right to revoke this authorization in writing unless Medical Records (PHI) has already been release or if otherw prohibited by state or federal law.

___ I have the right under the Federal Protected health Information regulations to make amendments where appropriate.

___ I understand that my health information may be subjected to re-disclosure by the recipient and not protected by fede and/or state privacy laws.

___ I understand that the authorizing of the disclosure of information identified above is voluntary and this Authorization is i intended to alter receiving healthcare and treatment services from any health care provider or payment for your healthcare.

___ I understand that I may see and copy the information described on this form if I ask for it and get a signed copy.

This information will expire on the following date or event: _____

THIS AUTHORIZIATION WILL EXPIRE ONE YEAR FROM THE DATE SIGNED, UNLESS OTHERWISE INDICATED.

_____ _____

Patient's signature Date

_____ _____

Legal Guardian signature, if applicable Date

State of _____

County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, _____

by _____.

_____

Print name: _____

Commission expires: _____

Personally known _____ or

Produced identification _____ Type of identification: _____