KWTTS's Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____ First Name _____MI ___

DOB:___/___/____

Client Address

_____

Client Home Phone: _____ Cell/Work Phone:_____

Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____

Phone: _____

Address: _____

Date of Authorization: ___/___/_____

Authorization to expire on ___/___/_____ or upon the happening of the following event: _____

_____

Information to be Released (Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)

Please Specify:

_____My entire mental health record

_____Only those portions pertaining to:

_____

(Specific provider name and/or dates of treatment)

Authorization for 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 _____ Payment of insurance claim _____Legal investigation

____Applying for insurance _____Vocational rehab, evaluation _____ Disability Claim

_____ At the request of the individual _____

Other (specify)_____

Authorization and Signature:

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____

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

Legal authority:

_____ Parent

_____Legal guardian

_____Representative of deceased