Authorization and Consent for Release of Information

Patient's Name_____ Date of Birth_____

I, the undersigned, authorize

_____

Name/Title Address Phone/Fax

and the office staff to release protected health information **from** your clinical record **to** only the following:

_____

Name/Title Address Phone/Fax

Specific purpose of disclosure _____

Information authorized to be released from the clinical record:

[ ] Psychiatric Hospital Records
[ ] Psychological Test Results
[ ] Laboratory Test Results
[ ] Other _____
[ ] Medical Progress Notes
[ ] Vocation Test Results
[ ] Educational Record

Date consent given ____/____/____ Expiration date ____/____/____Or event _____

This authorization will remain in effect until the above expiration date or event

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient if Guardian

Psychotherapy Notes: You are not required to authorize the release of psychotherapy notes to anyone at anytime. In addition, treatment, payment, enrollment or eligibility for benefits cannot be conditional upon your authorization.

I, the undersigned, authorize (*clinician*) _____ and the office staff to release your psychotherapy notes to the aforementioned party.

_____ Date consent given ____/____/____

Signature of Patient or Legal Guardian Expiration Date ____/____/____

Or event _____

Relationship to Patient if Guardian: _____

An authorization may be revoked at any time in writing without penalty of any kind. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I revoke my authorization for the release of the following:

[ ] Psychiatric Hospital Records
[ ] Psychological Test Results
[ ] Laboratory Test Results
[ ] Other _____
[ ] Medical Progress Notes
[ ] Vocational Test Results
[ ] Educational Record
[ ] Psychotherapy Notes

_____ _____

Signature of Patient or Legal Guardian Date Revoked

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I understand that my records are protected under Federal (42 CFR Part 2) and/or state confidentiality regulations. Upon revocation of authorization, further release of information shall cease immediately. File copy is equivalent to the original. This release of information expires in thirty (30) days following completion or termination of treatment, whichever is later. Federal regulations (42 CFR Part 2) prohibit anyone who receives these records from any further disclosure of it without specific written consent to the person to whom it pertains. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient's records. For the purpose hereof, "Medical Records" shall include all confidential HIV related information (as defined in ARS Section 36-661), confidential communicable disease related information (as defined in ARS Section 36-661), confidential alcohol or drug abuse related information (as defined in 42 CFR Section 2.1 ET SEQ), confidential mental health diagnosis/treatment information and genetic testing information (as defined in ARS Section 12-2801).