AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Please read carefully and fill out this form completely. All sections of this form must be completed before I am permitted to disclose your protected health information.

EXPLANATION: This form authorizes the use or exchange/disclosure of protected health information in the manner described below and is voluntary. Please be aware that once the information leaves my office my office I will no longer be able to protect that information and the recipients of your information may not legally be required to protect your information. Federal and state laws require me to obtain specific authorization to release sensitive information. Sensitive information is defined as treatment or documentation related to HIV and AIDS testing, psychiatric, psychological, alcohol or drug abuse treatment.

RESTRICTIONS: I understand that Suzanne Mathews, Ph.D. may not further use or disclose the protected information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release Suzanne Mathews, Ph.D. from any/all legal liability that may arise from the release of this information to the party named in this form. Suzanne Mathews, Ph.D. shall not condition treatment upon the signing of this authorization and client has the right to refuse to sign this form.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request.

DURATION: I understand that I may revoke, in writing, this authorization at any time, except to the extent that action has already been taken. Unless otherwise noted, this authorization will expire one year from the date of my signature.

1. Authorization: I authorize exchange/ disclosure of protected health information as described below:

   Name of patient: _____
   Date of Birth: _____
   Social Security Number (Optional) : _____
   Telephone: _____

2. I authorize the release of my PHI to:

   Name: _____
   Address: _____
   _____
   Telephone: _____

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3. Type of Information:

This authorization will not apply to the following types of information unless my initial appears beside each applicable category:

Psychiatric/Psychological records: _____ Drug/Alcohol Treatment: _____

Please specify the information that is authorized to be released:

Full Record _____ Treatment Summary _____
Progress Notes _____ Diagnosis _____

Other (if none of the above categories are applicable or are too general/broad, please specify the exact information to be disclosed)

_____
_____
_____

4. Dates of Service: From _____ To_____

5. Use of Information:

This individual or entity identified above is permitted to use my information for the following purposes: Please initial all that apply.

Continuing Care: _____ Second Opinion: _____
Personal: _____ Legal: _____
Insurance: _____
Other (please specify): _____

6. Duration:

This authorization is valid for one year from the date next to my signature unless otherwise noted here:_____

7. Signature:

Printed Name: _____
Signature: _____
If signed by other than patient, indicate relationship to patient: _____
Date/Time: _____

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