Youth and Family Services

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client: Last Name ____ First Name ____ MI ____ Date of Birth ____

I hereby authorize:
(Name, fax, and phone number of releasing facility)

____
____
____

☐ To release information to and/or
☐ To obtain information from:
(Individual name, facility/organization, and fax/phone)

Reason(s) for releasing information:

☐ Client's request
☐ Review client's current care
☐ Other (please explain) ______________________________
☐ Treatment/continued care
☐ Payment
☐ Insurance application
☐ Legal

Information to be released: Between the dates of ____________ to ____________.

Important: Indicate only the information that you are authorizing to be released.

☐ Discharge summary
☐ Care/treatment plan
☐ History/Physical/Initial evaluation
☐ Psychiatric assessments
☐ Progress notes
☐ CD counselor/therapist record
☐ Medications
☐ Immunizations
☐ Correspondence
☐ Exchange of verbal communication
☐ Other (specify content and dates): ______________________________

The following information requires special consent by law in order to be released. You must specifically request the following information in order for it to be released:

☐ Chemical dependency program
☐ Psychotherapy notes

☐ Billing record
☐ Photographs, video, digital, or other images

Acknowledgment of Understanding:

- I understand that by signing this form, I am requesting that the health information be sent to the third party named above.
- I may stop this consent at any time by writing to the organization(s), facility(ies), and/or professional(s) named above. If the organization, facility, or professional named above has already released health information based on my consent, my request to stop will not work for that health information.
- I understand that when the health information is sent to the third party named above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.
- I understand that if the organization named above is a health care provider, they will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the consent form.
- If I choose not to sign this form and the organization named about is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:
Date ____/____/____ or specific event ______________________________

______________________________ Signature of client, parent of minor, or legal guardian ____________ Relationship ____________ Date