Dr McNulty & Associates

Authorization for Use or Disclosure of Protected Health Information

Client Information

Last Name_____ First Name _____ DOB_____

Address_____

Phone: _____Email_____ _____

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.*)

□ 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:
_____

INITIAL_____

Purpose of Information Release:

□ Further mental health care
□ Applying for insurance
□ At the request of the individual

□ Payment of insurance claim □ Legal investigation □ Vocational rehab, evaluation □ Disability determination □ 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_____

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 □ incompetent □ disabled □ deceased Legal authority: □ parent □ legal guardian □ representative of deceased