HEALTHY MINDS
Healthy Lives

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Name of Person whose PHI is authorized to be exchanged:

CLIENT NAME: DOB:

ADDRESS: PHONE:

The following person or organization and Healthy Minds are authorized to **release and exchange** the information specified below. This authorization is reciprocal, Healthy Minds and the person or organization listed below may release information back and forth to each other. When receiving information, neither party shall re-disclose or transfer any of the information or records to other parties not listed below; doing so may subject them to civil and criminal liability.

Name of Person(s)/Organization(s) authorized to exchange PHI with:

NAME: _____ ROLE: _____
NAME: _____ ROLE: _____
NAME: _____ ROLE: _____
NAME: _____ ROLE: _____

PURPOSE OF DISCLOSURE IS: To gather/give information necessary for accurate diagnosis, treatment, and/or discharge for up to one year of signature date.

Specific information to be exchanged (please **INITIAL** all that apply):

___ Intake/Discharge Summary ___ Diagnosis and treatment plan ___ Discharge summary
___ Psychiatric Progress Notes ___ Current Medication(s)
___ Treatment Team Summary
___ Evaluations and Assessments ___ School Records and IEP ___ Psychological testing
___ Academic information/Classroom behavior ___ Status of Treatment
___ Probation Plan
___ Appointment dates and Times ___ Probation Plan ___ Drug Court Information
___ Legal Information/Court Documents ___ * Complete Records ___ *History and Physical
___ Other (specify)

_____

I understand that I do not have to authorize the release of information to receive treatment but that refusing to do so may result in a less accurate diagnosis and treatment plan. I understand that once my health information is released to the person or organization listed above, Healthy Minds cannot guarantee that the information will not be released to someone else or be protected.

I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this authorization. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise proved for in the regulation.

I understand that I may change my mind at any time and cancel this authorization in writing by e-mailing the request to: records@healthymindslv.com. If I cancel an authorization, I understand that the cancelation becomes effective when Healthy Minds receives the written request and that I cannot cancel authorization for information that has already been released in response to this authorization. This authorization will expire one year from the date of signature.

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I acknowledge and hereby understand that releasing my health records may contain information relating to alcohol, drug abuse, genetic information, sexually transmitted disease, psychiatric/mental health, HIV testing, HIV results or AIDS information.

Signature of Patient or Legal Representative: _____ Date: _____

Print Name *(of signer and patient if different)*: **_____ Date: _____**

Legal Representative Relationship: _____ Date: _____