



AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTHCARE INFORMATION

I authorize STEPHANIE UPCHURCH to DISCLOSE INFORMATION OBTAIN INFORMATION

PATIENT INFORMATION

PROVIDER INFORMATION

Patient Name			Previous Name		DOB	Agency/Facility/Person			Relationship to PT		
Patient Address						Address					
City		State		Zip Code		City		State		Zip Code	
Home Telephone #				Cellphone #		Telephone #				Fax #	

INFORMATION TO BE OBTAINED: VERBAL WRITTEN INFORMATION TO BE DISCLOSED: VERBAL WRITTEN

For the following treatment date(s) of: _____

This request and authorization applies to:

- | | | |
|---|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Substance Abuse Findings | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Psychiatric Assessment/Evaluation Findings | <input type="checkbox"/> Psychological Findings | <input type="checkbox"/> Legal records |
| <input type="checkbox"/> Medications/Medication Profile | <input type="checkbox"/> Psychosocial Assessment | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Educational Planning Information | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Entire Record for the following date of services _____ to _____ | | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> CHECK HERE IF YOU DO NOT WANT HIV TEST RESULTS (IF THEY EXIST) TO BE DISCLOSED | | |

RELEASE VIA MAIL FAX SECURE EMAIL

EXPIRATION: This authorization shall remain in effect for continuous treatment between levels of care or is effective for a time period of ONE (1) YEAR from the date of signature unless otherwise specified here _____ (insert expiration date).

Purpose of Disclosure: (check all that apply)

- Further Care Obtain Collateral information Insurance Personal Reasons Verify Treatment Compliance
 Other: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that the information to be disclosed includes issues discussed in treatment or documented in my medical record which may include diagnosis and/or treatment of alcohol/substance abuse, mental illness, developmental disabilities, STD's, genetic testing results, and/or HIV test results. I understand that I have the right to inspect and/or receive a copy of the health information to be used and/or released by this authorization. I understand that I may be charged a fee for any copies of the medical record I receive. I understand that I do not need to sign this authorization in order to receive treatment. I understand that I may revoke this authorization. I must do so in writing and present my revocation to my therapist for placement in my medical record. I understand that my revocation will not be effective as to uses and/or disclosures: 1) already made in reliance to this authorization or 2) needed for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition of obtaining insurance coverage. Re-disclosure Notice: I understand that the information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards. Photocopy/facsimile copy is as valid as the original document.

SIGNATURE OF PATIENT: _____ Date: _____

SIGNATURE OF LEGAL REPRESENTATIVE: _____ Date: _____

If signed by a Legal Representative complete the following:

- 1) Individual is a minor legally incompetent or incapacitated deceased 2) Legal authority: parent legal guardian next of kin/ executor of deceased activated POA for healthcare