AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

*The purpose of this form is to authorize **Dr. Mark Glover** to share protected health information with the identified third party for the purposes of treatment, payment, and health care operations. If you refuse to authorize any such disclosure, complete the grey box labeled "Restriction on Disclosure." Otherwise, please complete the form as indicated.*

MEMBER:

_____ _____

Last Name First Name MI Date of Birth

THIRD PARTY:

_____

Organization/Individual Name

_____

Address

_____

Telephone/Fax

I authorize ***Dr. Mark Glover*** to (initial all that apply):

_____release to _____obtain from _____discuss with

the third party identified above the specified protected health information listed below for purposes of treatment, payment, and health care operations.

INITIAL EACH APPLICABLE ITEM:

_____ Admission Evaluation Report
_____ Diagnosis Only
_____ Treatment Plan(s)
_____ Psychiatric Consultation Report
_____ Psychological Evaluation Report
_____ Discharge Summary
_____ Progress Review(s)
_____ Alcohol and Drug Treatment Information
_____ Hospitalization Screening
_____ Progress Notes from _____ to _____
_____ Medical Reports
_____ Legal Reports
_____ Education Reports
_____ HIV/AIDS Information
_____ Other: _____

This authorization shall remain in effect until _____ (date) at which time this authorization expires.

I UNDERSTAND that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing written notice of revocation to ***Dr. Mark Glover.***

I UNDERSTAND that my records are protected under Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 C.F.R. §2.32) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. **I specifically authorize the release of confidential information relating to drug and/or alcohol abuse.**

_____

Signature of Member/Member Representative Date

_____

Printed Name of Member Representative and Relationship to Member Representative Address and Phone Number

_____

Signature of Witness

RESTRICTION ON DISCLOSURE: The sharing of protected health information between any third party who has or is treating the Client and ***Dr. Mark Glover*** for the purposes of treatment, payment, or health care operations is not authorized.

_____ _____

Signature of Member/Member Representative Date

_____

Printed Name of Member Representative and Relationship to Member Representative Address and Phone Number

_____

Signature of Witness

Original to be Filed in Client Record. Copy to Client or Client Representative.