Confidential Authorization to Use/Disclose Protected Health Information

Client name: Date of Birth: Social Security #:

I authorize Katharine Townsend, Ph.D. to release and receive the specific health and medical information described below with:

Name of Person or Agency: Phone Number: Fax Number:

The information to be released or received includes:

[ ] intake summary/report [ ] discharge summary/report [ ] confirmation of services
[ ] entire psychological record [ ] treatment summary
[ ] other_____
[ ] with the following exceptions_____

The information is to be disclosed for the purpose of:

[ ] Evaluation or Diagnosis
[ ] Continuity of Care/Coordination of Services
[ ] Other: _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____HIV/AIDS Information
_____Mental Health Information
_____Genetic Testing Information
_____Drug/Alcohol Diagnosis, Treatment, or Referral Information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS Information, Mental Health Information, Genetic Testing Information, and Drug/Alcohol Diagnosis, Treatment, or Referral Information.

You do not need to sign this authorization in writing at any time. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services, unless: the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make the disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. Any use of disclosure already made cannot be undone. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, send a written statement to Katharine Townsend, Ph.D. at the address listed below.

This written authorization is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below this authorization shall expire one year from the date signed.

Other (specify date/event): _____

I hereby authorize the following: (signer to initial for authenticity)
_____ Release of my records via FAX machine. I accept the risk of misdirected information via misdialed phone number and misdirected release within the receiving facility/company.

I have read this authorization and I understand it.

_____ _____
Client signature Date

_____ _____
Witness signature Date

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