INSIGHTFUL MATTERS

FAMILY COUNSELING PROFESSIONALS

Authorization for Use or Disclosure of Protected Health Information

Client Information

Name:_____Birth date:_____/_____/ _____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number, City, State, Zip)

Phone:(_____)_____-_____E-mail:_____

Description of information (Check all that apply)

☐ Assessment/Evaluation
☐ Diagnosis
☐ Entire Medical Record - Only Released to a 3rd Party (Lawyer, Physician, etc.)
☐ Other (specify): _____
☐ Results of Psychological Tests
☐ Discharge Summary
☐ Treatment Plan History
☐ Psychotherapy Notes - Only Released to a 3rd Party (Lawyer, Physician, etc.)

Purpose of Disclosure (Check all that apply)

☐ Further mental health care
☐ Applying for insurance
☐ At the request of the individual
☐ Payment of insurance claim
☐ Other (specify): _____
☐ Vocational rehab, evaluation
☐ Legal investigation
☐ Disability determination

Recipient Information

I,_____, do hereby authorize Insightful Matters Family Counseling Professionals, Inc.:

(Check all that apply)

☐ To release my information to the person or facility below.

☐ To receive my information from the person or facility below.

Name of person/facility releasing/receiving information: _____

Phone: (_____)_____-_____

Address: _____
(Street and Number, City, State, Zip)

Date of Authorization:_____/_____/ _____

Authorization to expire on:_____/_____/ _____

or upon the happening of the following event: _____

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 (client) 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:

Client is: ☐ Minor ☐ Incompetent ☐ Disabled ☐Deceased

Legal authority: ☐ Parent ☐ Legal Guardian ☐ Representative of Decease