**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION**

|  |  |  |
| --- | --- | --- |
| Client Name | DOB | SSN or Client ID |
| Client Parent/Guardian |  |  |

**I authorize Kelley Bryan Gin, PsyD to share written and oral information (two-way or reciprocal release) about my needs and the services I receive:**

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| --- |
| Phone Number:                                                                              Fax: |
| Department: |

**With the following persons or facility:**

|  |
| --- |
| Individuals or Facility: |
| Address: |
| Phone Number:                                                                              Fax: |

**PURPOSE OF DISCLOSURE:**

Treatment Coordination [ ] Transfer [ ] Legal [ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPECIFIC INFORMATION FOR DISCLOSURE:**  
Entire Record [ ] or Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Drug/Alcohol Abuse, Diagnosis, Treatment (42 CFR 2.34/2.35) Initial\_\_\_\_\_\_\_\_\_\_\_\_\_  
HIV/AIDS test results (HS 120980(g)) Initial\_\_\_\_\_\_\_\_\_\_\_\_\_  
Genetic Testing Information (HS 124980(j)) Initial\_\_\_\_\_\_\_\_\_\_\_\_\_

**Effective for dates covering \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and expiring \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if no date is indicated, then authorization will expire twelve (12) months from effective date)**

**Limitations on Information to be shared: (attach additional sheet if nec.)**

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**NOTICE:** Dr. Kelley Gin and many other organizations and individuals such as physicians, hospitals, health plans, and social services are required by law to protect the confidentiality of your health information. **If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal laws may no longer protect it.**

**YOUR RIGHTS:** This Authorization to release health information is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to obtain information in connection with eligibility or enrollment in a health plan, (2) to determine any entity’s obligation to pay a claim, or (3) to create health information to provide to a third party. For more information, please refer to my Notice of Privacy Practices.

You may revoke this Authorization at any time. Your revocation must be made in writing, signed by you, or your representative, and delivered to Dr. Kelley Gin. The revocation will take effect when it is received, except to the extent others have already relied on it.

**You are entitled to a copy of this Authorization.**

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Printed Name Signature (Patient / Parent / Representative)  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date Relationship to Patient  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Kelley Bryan Gin, PsyD Date