**PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

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| **PATIENT INFORMATION** |
| Patient Name: | Date of Birth: |
| Phone: | Email: |
| Address: |
| **INFORMATION TO BE DISCLOSED** |
| *I authorize the following health care provider to DISCLOSE my patient information:* |
| Name: | Title: |
| Address: |
| Telephone: | Fax: |
| *Please include the following:* |
| [ ]Full Record | [ ]Psychological Evaluation(s) | [ ]Progress Notes |
| [ ]Billing & Financials | [ ]Drug/Alcohol Records | [ ]Appointment Records |
| [ ]Other: |
| *Indicate the specific purpose of the disclosure:* |
| [ ]Coordination of Care | [ ]Transfer of Care | [ ]Other: |
| **RECIPIENT INFORMATION** |
| *I authorize the following person(s) or organization to RECEIVE my patient information:* |
| a. Name | Relationship: |
| Address: |
| Telephone: | Fax: | Email: |
| b. Name | Relationship: |
| Address: |
| Telephone: | Fax: | Email: |

I understand that if the authorized recipient of this information is *not* a health care provider or health plan covered by federal privacy regulations, the information he/she receives will no longer be protected by these regulations, and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that Carmel Psychology will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Carmel Psychology, 301 East Carmel Drive, D100, Carmel IN 46032

I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization.

This authorization expires (check one):

[ ] 1 year from the date below [ ] One-time disclosure only [ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Printed Name of Patient Signature of Patient

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Printed Name of Legal Representative Signature of Legal Representative:

If Legal Representative, indicate relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Witness Date