A Space for Healing
8500 Station Street, Suite 300J, Mentor, OH 44060
(440) 721.8979
ASpaceforHealing.com

# Authorization for Use or Disclosure of Protected Health Information

## Client Information

Client Last Name_____ First Name _____MI ___

DOB:___/___/____

Client Address

_____

Client Home Phone: _____

Cell/Work Phone: _____

Client Email Address: _____

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## Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____

Phone: _____

Address: _____

Date of Authorization: ___/___/_____

Authorization to expire on ___/___/_____ or upon the happening of the following event: _____

_____

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**Information to be Released** (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.*)

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__ My entire mental health record

__ Only those portions pertaining to: _____

(Specific provider name and/or dates of treatment)

__ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

__ Other:
_____

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**Purpose of Information Release:**

__ Further mental health care

__ Payment of insurance claim

__ Legal investigation

__ Applying for insurance

__ Vocational rehab, evaluation

__ Disability determination

__ At the request of the individual

__ Other (specify): _____

**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 Date

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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:

Patient is: __ minor __ incompetent __ disabled __ deceased

Legal authority: __ parent __ legal guardian __ representative of deceased