

Behavioral Healthcare Consultants
Standard Authorization Form to use and disclose Protected Health Information

1. I am completing this form to allow the use and sharing of Protected Health Information about:

Printed name: _____ Date of Birth: _____

2. I authorize _____
therapist name and business/organization name

3a. To use, receive or disclose the following information: _____

3b. Dates of care included: _____

4. To / from (cross out one) this person or organization _____

5. The information will be used/disclosed for the following purposes: _____

6. I understand and agree that this Authorization will be valid until revoked. I understand that after that date or event, no more information can be used or released to the person or organization unless I sign a new authorization like this one.
7. I understand that I can revoke or cancel this authorization at any time by sending a letter to my therapist and/or the Privacy Officer of the organization listed above that is to supply this information. If I send a letter, it will prevent any release of information after the date it is received but can not change the fact that some information may have been released before that date.
8. I understand that I do not have to sign this authorization and that my refusal to sign usually will not affect my ability to obtain treatment from the professional or facility listed in number 4 above, nor will it affect my eligibility for benefits. If a refusal does affect my treatment or benefit, I will be notified immediately.
9. I understand that I may inspect and have a copy of the health information described in this authorization.
10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.
11. I understand that this professional or facility will receive compensation for the use or disclosure of my health information. This has been explained to me and I understand and accept it. (Does not apply)
12. I affirm that my questions regarding this form have been fully answered and I believe I now understand all of it.

Signature of client or his or her personal representative

Date

Printed name of client or personal representative

Relationship to the client

Description of personal representative's authority

I acknowledge that I received a copy of this completed form. I do not want a copy of this form.

I, a health professional, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of professional

Printed name of professional

Date