AUTHORIZATION FOR RELEASE / OBTAINING PROTECTED HEALTH INFORMATION

I agree to allow Dr. _____ of **Hidden Springs Psychological Services** to;
RELEASE TO: _____ OBTAIN FROM: _____
Check appropriate line

_____
(Name and address of Person or Organization authorized to Receive / Release Information)

(Please specify the extent and nature of information to be released or obtained)

Client's Initials	Information	Client's Initials	Information
_____	Clinical Intake & Assessment	_____	Progress Notes
_____	Treatment Plan, Goals	_____	Testing Report
_____	Other (Specify) _____	_____	

The information and material authorized for release may be used only for the purpose(s) indicated below. Initial all that apply:

Client's Initials	Information	Client's Initials	Information
_____	Verification of Services	_____	Ongoing Service Coordination
_____	Legal Matters	_____	Treatment / Service Planning
_____	Other (Specify) _____		

This authorization for releasing / obtaining the above information is to in effect through _____ unless otherwise revoked. (Not to Exceed One Year for Adults / Six Months for Children / Adolescents)

- I expressly acknowledge that this authorization is voluntary _____Client Initials
- The following are other limitations that I make regarding this authorization:
  _____
  _____
  _____

I understand that **Hidden Springs Psychological Services** needs my specific consent to disclose information pertaining to treatment or diagnosis of substance abuse and/or HIV status. In no event may any information, if applicable, be disclosed without my specific consent, unless required by law.

Indicate by your initials your specific authorization to release such information as applicable.

_____ I authorize the release of information that refers to treatment or diagnosis of drug or alcohol abuse.
_____ I authorize the release of information, which refers to treatment or diagnosis of HIV infection, or AIDS. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, education, life insurance, and social and family relationships.

- I understand that **Hidden Springs Psychological Services** _____will _____will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
- I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
- I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.
- I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.
- This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand the authorization form and all of its contents.
- I understand that this authorization is valid until _____/_____/_____ or until _____
  (Not to exceed one year for adults or six months for children and adolescents.)
- I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED BY ME AT ANY TIME.
- I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW ANY INFORMATION PRIOR TO IT BEING RELEASED.

Client Name: _____ **Date of Birth:** _____

Signature:_____ _____
Client, Parent, Guardian, Authorized Person Date

Witness: _____ _____
Date

REVOCATION OF AUTHORIZATION

I hereby **REVOKE THIS AUTHORIZATION** for the releasing/obtaining of information.

Client Name: _____ **Date of Birth:** _____

Signature:_____ _____
Client, Parent, Guardian, Authorized Person Date

Witness: _____ _____
Date