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Authorization to Use and Disclose Protected Health Information (PHI)

I am completing this form to allow the use and sharing of PHI about: _____
(patient's name) **(patient's birthdate)**

I authorize the following person/organization to disclose the following PHI:
(Who is SENDING the PHI?) __Ariel Gonzales __Other: _____

If "other," Phone: _____ Fax: _____ Address: _____

__Records (inpatient, outpatient, and day/residential) for physical or psychiatric illness; admission/discharge summaries; psychiatric, psychological, or social work evaluations/assessments/reports/summaries or other documents including testing, diagnoses, prognoses, or recommendations; checklists/behavioral observations or similar documents completed by the client/family or any staff member; social work, recovery, treatment, rehabilitation, aftercare, or other similar plans; social, family, educational, or vocational histories; progress, nursing, case, or similar notes; HIV related PHI contained in the above records;

__ Evaluations and reports of consultants;

__ PHI about how the client's condition(s) have affected/affect his/her ability to work or complete tasks/activities of daily living; vocational evaluations or reports;

__ Academic/educational records including results of achievement and/or other testing, reports of teacher observations, and all other school or special education documents,

Other than these excluded documents **(PHI NOT to send)**: _____
(If left blank, no exclusions will be made.)

For the following dates of care **(send the PHI from these times)**: __all dates __from _____ to _____

To the following person/organization **(Who GETS the PHI?)**: __Ariel Gonzales __Other: _____

If "other," Phone: _____ Fax: _____ Address: _____

Two-way disclosures for the above record types (or the information therein) between the above persons/organizations:
I __do __do not authorize verbal two-way disclosures including **PHONE CALLS BETWEEN THEM**.
I __do __do not authorize **2-WAY RECORDS RELEASE**/disclosure between them.

This disclosure is for the following purpose(s) **(reason for this form)**: __ Treatment planning __ Other: _____

This authorization will be valid and in effect until the following date/event, after which PHI cannot be disclosed to the indicated person/organization without a new authorization **(form expires when):**
__ six months have passed without a visit with Ariel Gonzales __one year from now __other:_____
(If no date/event is specified, this authorization remains in effect for one year.)

I understand the following: I can revoke or cancel this authorization at any time by sending a letter to the person/organization supplying PHI, but this cannot reverse any disclosure occurring prior to receipt; I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or my benefit eligibility; if the person or entity receiving the PHI is not a health care provider or other entity covered by federal privacy regulations the above PHI may be re-disclosed and no longer protected by those regulations; this professional/facility may receive compensation for the use or disclosure of my PHI.

Anything in this form that was unclear to me has been explained and I believe I now understand it.

_____
(printed name) **(signature)** **(date)**

(Who signed? Check one:) __ Signed by the patient __ Signed by: _____
(relationship to patient, e.g. mother, guardian, etc.)

I have been offered a copy of this completed form. _____
(initials)

Witness (optional): _____
(printed name) (signature) (date)