Emmaus Counseling Center

Authorization to Use or Disclose Protected Health Information

Client's Name:____ Date of Birth:______________
(Please Print) LAST FIRST MI
Are medical records filed under another name?____
The person named above hereby authorizes (Requesting Provider)______________________________ to:

☐ Request Health Information from ☐ Discuss Information with ☐ Send Information to

The person named above authorizes information to be requested or released by representatives of:
Name of Provider or Facility: ____
Address:____
Fax:__________________________________Phone: ____________________________

Purpose of Disclosure:

☐ Continuity of Care ☐ Personal
☐ Legal ☐ Summary of Treatment & Progress
☐ Disability ☐ Insurance
☐ Other: ____

Specific Health Information Authorized:
☐ I authorize disclosure of all my health information, including information related to medical, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information, or

☐ I authorize **ONLY** the disclosure of the following information: ______________________________

Specific Health Information Requested (*Requesting Provider to complete*): ☐ **Entire Record/OR ONLY the following:**
☐ My records relating ONLY to the following treatment or condition: ___________________________
☐ My records only for the following date(s):____
☐ Billing purposes ONLY (providing billing statements to parent/guardian for payment*).
☐ Other: ____
***Minors (ages 13-17)**: A minor patient's signature is required to release the following information: (1) alcohol and/or drug abuse (age 13 and older), (2) mental health conditions (age 13 and older), and (3) billing information/client statements.____

I understand and agree that:

- This authorization is voluntary.
- My health information may contain information created by other persons or entities including heath care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive communicable diseases and health care program information.
- I understand that as an adult, I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider except to the extent that the information being requested may assist your health care provider in determining appropriate treatment.
- My health information may be subject to the re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy policy regulations.
- I understand that such information cannot be released without my informed consent.
- I acknowledge I have fully reviewed and understand the contents of this authorization form. This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying my provider in writing; however, the revocation will not have any effect on any actions taken prior to the date my revocation is received and processed.
- There may be a charge for copies of your records unless your copies are being sent to another physician or healthcare facility.

Authorization:
Signature of Client or Authorized Representative: ____

Date:____________________Relationship, if other than client: _________________________________