Authorization of the Release of Protected Health Information

FULL NAME _____ BIRTH DATE _____ GENDER_____
FIRST MI LAST

SS# _____ ADDRESS _____
STREET/APT CITY STATE ZIP CODE

HOME PHONE_____ CELL PHONE_____ EMAIL _____

PROTECTED HEALTH INFORMATION (PHI) TO BE OBTAINED OR DISLCOSED TO:

_____ _____ _____
NAME OF ORGANIZATION TITLE PHONE NUMBER

_____ _____
ADDRESS, CITY, STATE, ZIP CODE CONFIDENTIAL FAX NUMBER

TYPE OF INFORMATION TO BE DISCLOSED OR RECEIVED:

☐ Treatment Plan	☐ Outpatient Assessment	☐ Inpatient Assessment
☐ Medical History & Physical	☐ Discharge Summary	☐ Emergency Treatment
☐ Operative Reports	☐ Patient Follow-Up Report	☐ Social Work Assessment
☐ Laboratory Reports	☐ Consultation Reports	☐ Physician Orders
☐ Psychological Testing Reports	☐ All Psychotherapy Notes	☐ Billing/Payments

☐ Other,_____

I, the undersigned, hereby authorize a representative of The Family Therapy Center to use and/or disclose information from medical or financial record as specified above.

I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include documentation of treatment for mental health disorders, alcohol/drug abuse or dependence, and/or HIV/AIDs test results or diagnosis. I explicitly consent to the release of information as designated about. Furthermore, I consent to the release of the facsimile transmission of my protected health information as necessary.

This authorization will remain effective for one (1) year unless an earlier date or condition is specified here. _____

This authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the authorization the individual/parent/legal guardian must submit a revocation request in writing to the disclosure. I also understand that The Family Therapy Center may charge a reasonable fee for the preparation, copying and postage as allowed by state law for copies of medical records.

I understand that The Family Therapy Center will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this authorization. If the person/entity that received the above PHI is not a health care provider/health plan covered by federal privacy regulations, the PHI described above may be re-disclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

_____ _____ _____ _____
SIGNATURE PRINT NAME RELATIONSHIP TO CLIENT DATE

Please fax this completed form, Attention Medical Records, The Family Therapy Center at (513)939-0310 or mail it to us at 1251 Nilles Rd, Suite 4 Fairfield, Ohio 45014

This authorization was designed to comply with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), as well as with state insurance and other federal and state laws governing the use of authorizations and protected confidential health information.