AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DOB:\_\_\_\_\_\_\_\_\_) voluntarily authorize PSU Berks Counseling Services to:

\_\_\_\_\_ Exchange information necessary to coordinate mental health and/or medical care with:

\_\_\_\_\_ Release records/information concerning my mental health evaluation/treatment to:

\_\_\_\_\_ Obtain records/information concerning my mental health evaluation/treatment from:

Name of agency or person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of agency or person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Phone/fax numbers of agency or person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization is valid for 1 year from date of signature or expires on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information released will be disclosed for the following reason(s):

\_\_\_\_ Confirm attendance

\_\_\_\_ Continued care

\_\_\_\_ Provide information

\_\_\_\_ Coordination of care

\_\_\_\_ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The specific and relevant type of information I wish to have released is:

\_\_\_\_ Treatment summary

\_\_\_\_ Treatment/aftercare recommendations

\_\_\_\_ Dates of counseling appointments/treatment

\_\_\_\_ Testing/Assessment results

\_\_\_\_ Psychiatric evaluation and diagnoses

\_\_\_\_ Progress notes

\_\_\_\_ All treatment records

\_\_\_\_ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my record(s) may contain information related to alcohol/drug use, sexually transmitted diseases, sexual assault, and/or mental health. This information will be disclosed unless I specify that the information NOT be disclosed by initialing: \_\_\_\_ Alcohol/drug use \_\_\_\_ Sexually Transmitted Diseases \_\_\_\_ Sexual Assault \_\_\_\_ Mental health

I understand authorizing the use or disclosure of the information identified above is voluntary. I understand that my treatment at PSU Berks Counseling Services is not conditional on my signing an authorization. I understand I have the right to revoke/modify this authorization at any time by verbal or written request. However, my revocation/modification will only apply to future disclosures and is not retroactive. Please refer to the Notice of Privacy Practices for exceptions for revocation. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

Client signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Penn State ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like a copy of this authorization? \_\_\_\_\_ Yes \_\_\_\_\_No