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AUTHORIZATION TO DISCLOSE PROTECTED MENTAL HEALTH INFORMATION

Patient Name: SSN:
Address: Birthdate:
Telephone: Identity Code:

Healthcare Information From:	Release to:
Nancy Martin MA, LPC, Registered Play Therapist	

I authorize the above-named health care provider to disclose the privileged information specified below to the organization, agency, or individual named on this request:
INFORMATION REQUESTED:
Place/Dates of Service
Kind and amount of information to be disclosed
Purpose of disclosure/why information required

I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

AUTHORIZATION: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer or their designee and that it will expire at the end of litigation involving me. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. **This authorization expires six months from date of patient's or representative's signature below, unless otherwise specified:** _____. If I have authorized disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be valid as the original.

I understand that authorization disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee will be charged for any copy of my health record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the facility privacy officer or their designee.

Signature: _____ Date: _____
Patient (Parent or Guardian if patient is a minor)
Minor's signature is required for release of any records for treatment which the minor may authorized.
RELATIONSHIP (if other than patient): _____
IDENTIFICATION OF PATIENT OR DESIGNATED REPRESENTATIVE
Drivers License # _____ Passport # _____
State ID # _____ Other ID # _____