Sound Mind Counseling

# Patient Authorization for Disclosure of Protected Health Information

**RE:** Client name: _____ Date of birth: _____

Home phone: _____ Cell phone: _____

By signing this form, I, _____ (name), authorize that protected health information, including confidential psychological, psychiatric, or substance abuse information, can be released and/or discussed with the people or agencies listed below unless noted by exclusion or limitations.

| **Individual releasing/receiving information** | **Agency/individual receiving/releasing information** |
|---|---|
| Name of counselor: _____ | Name: _____ |
| Address: _____ | Address: _____ |
| City/state/ZIP: _____ | City/state/ZIP: _____ |
| Phone: _____ | Phone: _____ |
| Fax: _____ | Fax: _____ |

## Records period

From the past _____ year(s), or from _____ to _____

## Information to be released (check all that apply)

- ☐ Psychiatric/psychological evaluation
- ☐ Psychological testing
- ☐ Physical examination
- ☐ Alcohol and substance abuse (evaluation or treatment)
- ☐ Progress notes
- ☐ Discharge/service summaries
- ☐ Blood or urine test results (including HIV/AIDS)
- ☐ Other: _____

## Purpose(s) for releasing the information

- ☐ Continuation of care
- ☐ Consultation
- ☐ Other: _____

Exclusions or limitations:

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# Patient Authorization for Disclosure of Protected Health Information

## Expiration

This authorization will automatically expire in one year unless a different expiration date or event is specified.

Specified expiration date or event:

## Authorization and acknowledgement

This form is being signed voluntarily, and I may change my mind at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation. I understand that Dr. Kratimenos and/or Sound Mind Counseling assume no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Dr. Kratimenos and/or Sound Mind Counseling from all legal liability that may arise from this authorization.

I give my permission for a faxed or photocopied signature to serve as an original regarding this release.

## Signatures

Patient/legal guardian signature:

Date:

Witness signature:

Date:

## Optional contact information

Best phone number:

Preferred contact method:

A copy of this completed authorization may be provided to the patient or legal guardian upon request.