



AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH

Client Name: _____ DOB: _____

I _____ (client's name) authorize *Lisa Sciarani, LCSW/Your Path Forward* to
 OBTAIN information from DISCLOSE information to

Contact Name:	Organization/Relationship:
Address:	Telephone:
City, State, Zip:	Fax:

Information to be used/disclosed consists of mental health care information:

- All records, or Only the items checked below:
- Assessment or evaluation Treatment Plan Summary of Treatment
- Progress Notes Coordination of care information Other: _____

The purpose for the disclosure/communication:

- Coordination of care By request of the client Other: _____

I understand that additional laws about mental health, alcohol/drug treatment, genetic testing, and HIV/AIDS may apply. I understand and agree that this information will be disclosed if I initial next to the type of PHI.

	Type of PHI
<input type="checkbox"/>	Mental health information
<input type="checkbox"/>	Alcohol/drug diagnoses, treatment, or referral information
<input type="checkbox"/>	HIV/AIDS testing
<input type="checkbox"/>	Genetic testing

Client Acknowledgment and Authorization

I understand that I am not required to sign this authorization. If I decline to sign this authorization, it will not prevent me from getting care. I understand that I may revoke this authorization in writing at any time, at which time any information described here may no longer be used or disclosed. Any information that has been used or disclosed prior to the revocation cannot be unshared. I understand that any information used or disclosed as a result of this authorization may be subject to re-disclosure. However, I also understand that federal and state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing, and drug/alcohol diagnoses, treatment or referral information.

Unless revoked, this authorization expires **60 days after the completion of treatment** or: _____

 Client Signature

 Date

 Parent/Legal Guardian/Personal Representative Signature

 Date

 Parent/Legal Guardian/Personal Representative Name

Authority of representative: Parent Legal Guardian Power of Attorney/Healthcare Other: _____