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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Client's Name:_____ **Date of Birth:** _____

I hereby give consent and authorize Hugh S. Smith, Ph.D. & Associates, P.C. to allow the use and sharing of Protected Health Information (PHI) about the abovementioned person to:

_____

Information to be used or disclosed may include: (initial next to each desired):

_____ Social History
_____ Academic and Educational Records
_____ Psychological Evaluation
_____ Progress Notes
_____ Treatment Plan
_____ Aftercare Instructions
_____ Information regarding client's ability to work
_____ Referral/Treatment Summary
_____ Admission Summary
_____ Discharge Summary
_____ Other - List specific items: _____
_____

I understand that this Authorization does not cover psychotherapy notes, which require a separate Authorization..

HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here

☐ Do not release these

Dates of care included: _____

I understand this information is to be used specifically for the following purpose(s):

CONTINUITY OF CARE

I understand that I have no obligation whatsoever to disclose any information from my client record, that I do not have to sign this Authorization, and that my refusal to sign will not affect my ability to obtain treatment from Hugh S. Smith, Ph.D. & Associates, P.C., nor will it effect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this Authorization.

I understand that I may revoke or cancel this Authorization at any time, except to the extent that this agency has already acted upon it, by notifying Hugh S. Smith, Ph.D. & Associates, P.C., in writing. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR AFTER SIGNATURE

I have read this form or had it explained to me, and I understand its contents. I have been provided with a copy of this signed Authorization.

_____	_____	_____
Signature of client or his/her personal representative	Printed name of client or personal representative	Date Signed

_____
Description of personal representative's authority

I, a mental health professional have discussed the issues above with the client and/or his personal representative. My observations of his/her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	_____	_____
Signature of professional	Printed name of professional	Date Signed

NOTICE TO RECIPIENT OF INFORMATION: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE AND FEDERAL LAW. FEDERAL REGULATIONS (42 CRF PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.