Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____ First Name _____ MI ___
DOB:___/___/____
Client Address
_____
Client Home Phone: _____ Cell/Work Phone: _____
Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below:

Name of person/facility to receive medical information: _____
Phone: _____
Address: _____

Date of Authorization: ___/___/_____
Authorization to expire on ___/___/_____ or upon the happening of the following event: _____
_____

Information to be Released (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.*)

□ My entire mental health record

□ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)

□ Initial Intake □ Psychosocial Evaluation □ Treatment Plan

□ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

□ Other: _____

✉:: 8323 Southwest Freeway Ste 565 Houston, TX 77074-1633 ☎:: 281-971-2223 (Fax): 281-978-4946
:: drcratliff@ratliffconsultants.com www.ratliffconsultants.com

Revised: 10/18/2016

Purpose of Information Release:

□ Further mental health care □ Payment of insurance claim □ Legal investigation
□ Applying for insurance □ Vocational rehab, evaluation □ Disability determination
□ At the request of the individual □ Other (specify): _____

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____
Signature Date

If signed by a personal representative:

(a) Print your name: _____
(b) Indicate your relationship to the client and/or reason and legal authority for signing:
Patient is: □ minor □ incompetent □ disabled □ deceased
Legal authority: □ parent □ legal guardian □ representative of deceased

✉:: 8323 Southwest Freeway Ste 565 Houston, TX 77074-1633 ☎:: 281-971-2223 (Fax): 281-978-4946
:: drcratliff@ratliffconsultants.com www.ratliffconsultants.com

Revised: 10/18/2016