****Authorization to Use/Disclose Protected Health Information

Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Authentic Self Psychotherapeutic Services to release and receive the specific health and medical information described below with:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person or Agency Phone Number Fax Number

The information to be released or received includes:

[ ] Intake summary / report [ ] Treatment summary

[ ] Entire Psychological record [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Discharge summary / report

The information is to be disclosed for the purpose of:

[ ] Evaluation / Diagnosis

[ ] Continuity of Care/Coordination of Services

[ ] Other:

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

\_\_\_\_ HIV/AIDS Information  
\_\_\_\_ Mental Health Information  
\_\_\_\_ Genetic Testing Information  
\_\_\_\_ Drug/Alcohol Diagnosis, Treatment, or Referral Information

You **do not** need to sign this authorization in writing at any time. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services, unless: the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make the disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. Any use of disclosure already made cannot be undone. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, send a written request to Jasset Smith, Psy.D., at: 1920 Palm Beach Lakes Blvd., West Palm Beach, FL 33473

This written authorization is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below this authorization shall expire one year from the date signed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date