Catalyst
BEHAVIORAL HEALTH

Authorization for Use and Disclosure of Protected Health Information

I, _____(client/parent/guardian), hereby request and authorize Apryl Benedict, LICSW to release and/or receive Protected Health Information (PHI), as specified below, to/from:

Name of person/provider/Agency _____

Address _____

Phone/Fax/Secure Email: _____

Information authorized to release or receive (please check all that apply):

☐ Medical History and Physical	☐ Family & Social History	☐ Medication Information	☐ Psychological Testing
☐ Psychological Evaluation	☐ Treatment Plan	☐ Academic Records	☐ Lab Reports
☐ Psychiatric Evaluation	☐ Discharge Summary	☐ Hospital Records	☐ Entire Record
☐ Chemical Dependency Evaluation	☐ Substance Abuse History	☐ Attendance/Participation	☐ Other:

Information may be used for evaluation, treatment, educational planning, follow-up, continuity of care or for treatment. This authorization is good for one year from the date signed or for _____ days.

I have reviewed this authorization form and confirm that it reflects my wishes to release/receive protected healthcare information. I understand that any disclosure of information carries with the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. By signing this document, I release Apryl Benedict, LICSW from any liability resulting from this disclosure. I also have the right to revoke this authorization at any time and must do so in writing to the office manager at Catalyst Behavioral Health. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected. A photocopy or fax of this document shall have the same effect as the original.

Print Client Name: _____ DOB: _____

Client/Parent/Guardian Signature: _____ Date Signed: _____

Clinician Signature: _____ Date Signed: _____

Apryl Benedict, LICSW
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Creating Positive Change