# Authorization for Use and Disclosure of Protected Health Information

I, ________________________, hereby request and authorize Krysta Hunt, MA, LIMHP to release and/or receive
(client/parent/guardian)
Protected Health Information (PHI), as specified below, to/from ________________________________
(name of person/provider/agency)
at ______________________________________________________________________________.
(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 Eval. | □ Substance Use History | □ Attendance/Participation | □ Other: |

Information may be used for evaluation, treatment, educational planning, follow-up, continuity of care or for further medical 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 Krysta Hunt, MA, LIMHP 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.

**Patient Name:** ________________________________ **DOB:** ____________________

**Client/Guardian Signature:** ________________________ **Date Signed:** ________________
Note: If the patient is under the age of 19, the parent or guardian must sign all legal documents.

**Witness/Clinician Signature:** ________________________ **Date Signed:** ____________

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**Creating Positive Change**