Catalyst
BEHAVIORAL HEALTH

Authorization to Release Healthcare Information

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

Address: _____

I request and authorize M. B. Psychological Services, LLC to (check one):

___ Send and receive healthcare information.
___ Only send healthcare information.
___ Only receive healthcare information.

Information requested to be released (please check all that apply):

___ Entire Record
___ Diagnostic Evaluation
___ Progress Notes
___ Treatment Plan
___ Medical History/Medications
___ Psychological Testing
___ Discharge Summary
___ Information pertaining to alcohol and drug use
___ Information pertaining to HIV status
___ Other _____

To/From:

Name: _____

Address: _____

Phone: _____ Fax: _____

I understand this authorization will expire 1 year from the date signed or until _____. Information may be used for evaluation, treatment, follow up, continuity of care, or further medical treatment. I have reviewed this authorization and confirm it reflects my wishes to release/receive protected healthcare information. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. I understand that any disclosure of information carries the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. By signing this document, I release M. B. Psychological Services, LLC from any liability resulting from this disclosure. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I 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 was the original. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client Signature: _____ **Date:** _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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