



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):

<input type="checkbox"/> Medical History and Physical	<input type="checkbox"/> Family & Social History	<input type="checkbox"/> Medication Information	<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Academic Records	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Hospital Records	<input type="checkbox"/> Entire Record
<input type="checkbox"/> Chemical Dependency Eval.	<input type="checkbox"/> Substance Use History	<input type="checkbox"/> Attendance/Participation	<input type="checkbox"/> Other:

Information may be used for evaluation, treatment, educational planning, follow-up, continuity of care, or 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 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/Guardian Signature: _____ Date Signed: _____

*Note: If the client is under the age of 19, the parent or guardian must sign all legal documents.

Clinician Signature: _____ Date Signed: _____

Apryl Benedict, LICSW
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Creating Positive Change