



## Authorization for Use and Disclosure of Protected Health Information

I, \_\_\_\_\_, hereby request and authorize Hannah Couillard, MS. Ed., LMHP, CPC 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):

<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 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 Hannah Couillard, MS. Ed., LMHP, CPC 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 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**