Catalyst
BEHAVIORAL HEALTH

Authorization for Use and Disclosure of Protected Health Information

I, _____ (client/parent/guardian), hereby request and authorize Angela Hillman, 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 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 Angela Hillman, 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: _____

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Creating Positive Change