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Authorization to Release Protected Health Information

I, _____(client print name) authorize Greenhouse Therapy Center to exchange information with the following person or agency for the purpose of coordinating services or evaluation.

Individual or Agency name:_____

Address and Phone:
_____

_____

The following information is authorized to be exchanged:
____ Medical Records
____ Presence in therapy
____ Clinical history
____ Information necessary for course of therapy
____ Entire record
____ Other : _____

This authorization is valid for one year from date signed below or until:_____

I understand that I may revoke this authorization in writing at any time. Information exchanged previous to the time that I revoke this authorization will not be subject to the revoked authorization, but information received will no longer be used or disclosed for the purposes described in this authorization.

I understand that information disclosed due to this authorization may be subject to redisclosure and no longer protected under federal law. I understand that federal or state law may restrict redisclosure of specific health information, such as HIV/AIDS, mental health, drug and alcohol, and genetic testing information.

I understand that I do not have to sign this authorization and that refusal to sign will not adversely affect my ability to receive services. The only circumstance when refusal to sign this authorization restricts services is if the services are solely for the purpose of providing health information to someone else and authorization is needed to make the disclosure.

Signature: _____ DOB: _____ Date: _____