Authorization to Release Protected Patient Health Information

INFORMATION AUTHORIZED FOR RELEASE TO/FROM:

I, _____ authorize the following professionals or specified individual:
(Patient)

☐ Christina M. Caro, PhD, Clinical Psychologist, P.O. Box 7055, Mammoth Lakes, CA 93546 (408) 768-8636
☐ _____ of _____
(Name of Professional, Title) (mailing address and phone)

to release information as follows to:

☐ Christina M. Caro, PhD, Clinical Psychologist, P.O. Box 7055, Mammoth Lakes, CA 93546 (408) 768-8636
☐ _____ of _____
(Name of Professional, Title) (mailing address and phone)

Specific information requested:
☐ Physical Health Records
☐ Physical Health Clinical Summary
☐ Mental Health Clinical Summary
☐ Alcohol and/or drug treatment summary
☐ Treatment Progress
☐ Treatment Issues

For the purpose of:
☐ Patient Request
☐ Health care provider treatment coordination
☐ Behavioral health treatment assessment/planning
☐ Academic/Vocational reasons
☐ Legal reasons
☐ Collateral treatment plan support
☐ Other: _____

SCOPE OF AUTHORIZATION

_____ I understand that if this Authorization is for the Provider's own use and disclosure or to allow another health care professional or health care entity to disclose information to the provider: (1) the provider cannot deny services or treatment to me if I refuse to make this signed authorization; (2) I have the right to inspect a copy of the protected health information to be used or disclosed; (3) I may refuse to sign this Authorization; and (4) the Provider must provide me with a copy of the signed authorization.

_____ I understand I have the right to revoke this Authorization at any time, provided that I **do so in writing** and except to the extent that the provider already used or disclosed the information in reliance on this Authorization.

_____ I understand that protected health information will be kept for 7 years before being destroyed or disposed of.

_____ I understand that, in order to keep the information longer than the time specified, I must be notified of the extension and the specific reason for the extension, the intended use of the information during the extended time and the expected date of the destruction of the information.

_____ I understand that the information will not be used for any purpose other than its intended use.

_____ I understand that the person/entity requesting the information will destroy it and all copies of it in the person/entity's control, will cause it to be destroyed or will return it and all copies of it to me, before or immediately after the length of time specified above has expired.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

By signing this Authorization, I understand I am directing my provider to disclose my health information to a person or organization that may not have the same obligations to protect privacy required of health care practitioners, health plans and other health care entities observed under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

_____ I understand that I may request that my provider require the recipient of my protected health information to sign a **Confidentiality Agreement** in which the recipient agrees to limit its use and disclosure of my information as specified by the **Confidentiality Agreement**. If the intended recipient refuses to sign the confidentiality agreement you request, my provider will not release the information.

☐ **Yes,** I request that the recipient of the information identified above for disclosure sign a Confidentiality Agreement. (Initial:_____).

☐ **No**, I do not request that the recipient of the information identified above for disclosure sign a Confidentiality Agreement. (Initial: _____).

_____ I understand that my alcohol and/or drug treatment records are protected under federal and state regulations (42 CFR Part 2 and ORS 430.399(5), 179.505) governing Confidentiality of Alcohol and Drug Abuse Patient Records, and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

_____

(Specify the date, event, or condition upon which the Authorization expires)

☐ I have received a copy of the written request for my outpatient psychotherapy records 30 days prior to sending the requested information, *or* ☐I hereby waive my right to receive this request 30 days in advance and declare this release to constitute my letter submitted to the provider of health-care waiving notification.

_____ I understand the professional (above) is not authorized to disclose information to any other person/entity without my consent.

_____ I understand that I may revoke this authorization at any time.

Patient Name (printed): _____ Provider Name: _____

Patient Signature: _____ Provider Signature: _____
Date: _____ Date: _____