Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____ First Name _____MI ___

DOB:___/___/____

Client Address:_____

Client Home Phone: _____ Cell/Work Phone: _____

Client Email Address: _____

Recipient Information

I, _____, do hereby authorize Healing Harmony Health and Wellness with Shana, LLC to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____
Phone: _____ Fax: _____
Address: _____

Date of Authorization: ___/___/_____
Consent is granted:

☐One time ☐One Year ☐Other, please specify _____
Cannot exceed one year

Information to be Released (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.*)

☐My entire mental health record

☐Intake/ Closing Summary

☐Employment Information

☐Substance Abuse and/or Alcohol Treatment Records

☐Psychotherapy Progress Notes* (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

☐Diagnosis

☐Treatment Plan/ Summary

☐Letter/ Summary of Services

☐Sexual Abuse/ Assault Counseling Records

☐Billing/ Financial Records

☐Other: _____

_____

Only those portions pertaining to:
_____ (Specific provider name and/or dates of treatment)

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Purpose of Information Release

☐Coordination of care

☐Further mental health care

☐Transfer of Care/ New Provider

☐Insurance/ Billing

☐Personal Records

☐Legal/ Court Hearing

☐IEP/ School

☐Confirmation of Services

☐Disability Determination

☐Other: _____

_____

Format of Records to be Released

☐Paper/ Hard copy

☐Electronic/ Email

☐Verbal

☐Other

Fees*: Fees are authorized annually by state law. Fee must be paid before records can be released. Paper copies: Maryland: 76¢ per page Copies totaling under 20 pages are free

Some exceptions apply; case by case basis

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____

Signature Date

If signed by a personal representative:
(a) Print your name: _____
(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is:

☐Minor

*(A minor who is 16 years or older has the same capacity as an adult to consent to consultation, diagnosis, and treatment of mental or emotional disorder by physician, psychologist, or clinic [Md. Code Ann., Health-Gen II §20-104 (a)])

☐Incompetent

☐Disabled

☐Deceased

Legal authority:

☐Parent ☐Legal guardian

☐Representative of deceased