# SPECTRUM BEHAVIORAL HEALTH

Dedicated Mental Health Professionals since 1978

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## PATIENT RELEASE OF PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

**PATIENT NAME:**______________________________________________________
**DATE OF BIRTH:**______________________________________________________

This form when completed and signed by you, authorizes me to release protected health information from your clinical record to the person(s) you designate and vice versa.

I authorize my clinician, ______________________________________ and/or his or her administrative staff to release and/or receive:

______________________________________________________________________

______________________________________________________________________

This information should only be released to or received from:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

I am requesting my clinician to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not wish to state a specific purpose.)

______________________________________________________________________

I understand that my clinician cannot re-disclose information he/she received from another health care provider if that health care provider requested that the information not be re-disclosed.

This authorization shall remain in effect until ____________________(up to 1 year).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address.  However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my clinician generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

____________________________________      _________________________

Signature of Patient/Guarantor      Date

____________________________________      _________________________

Spectrum Representative Signature-Witness      Date

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If the authorization is signed by a personal representative of the patient, a description of such representative’s authority to act for the patient must be provided.