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Authorization for Release of Information

Client Name: ______________________________ **Date of Birth:** ____________________

This form, when completed and signed by you,

☐ authorizes me to release protected information from your clinical record to the person you designated and
☐ authorizes the person you designated to release information to me.

Name/Organization: ____

Address: ____________________ **City:** ______________ **State:** ________ **Zip:** ____________

Telephone: ________________________ **Fax:** ________________________

This authorization for disclosure of protected information applies to the following types of information:

☐ Clinical Information ☐ Clinical Record ☐ Other (please specify): ____________________

This authorization pertains or relates to information regarding myself and/or the following minor child/children of whom I am the parent or legal guardian:

Name: ______________________________ **Date of Birth:** ____________________

Name: ______________________________ **Date of Birth:** ____________________

I understand that my records may contain protected information regarding diagnosis and/or treatment for HIV (AIDS virus) or other sexually transmitted diseases, drug/alcohol diagnosis and/or treatment, and/or Mental Health diagnosis and/or treatment. ***I give consent to release information regarding all of the following: (please initial next to each area)***

_____ HIV/AIDS **_____ Drugs/Alcohol** **_____ Mental Health**

I am requesting the release of information for the following reason, and subjects to the following limitations:

☐ Continuity of Care ☐ Other (please specify): ______________________________

Limitations: ____

This authorization shall remain in effect until: (Fill in an expiration date or an event that relates to the purpose of the disclosure.) ☐ Termination of Services ☐ Other (please specify): ______________________

If this authorization does not contain an expiration date or event, it expires 90 days from the date of signature.

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

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

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

Signature of Client: ______________________________ Date: ____________________

Signature of Parent/Legal Guardian/DPOA: ________________________ Date: ________________

Provider Signature: ______________________________ Date: ________________

Note: A photocopy or facsimile of the above signatures shall be considered in lieu of original. **If there is a fee for this service, please obtain prior approval from Dr. Dennis Dyck.**