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Mental Health Records Release and Specific Authorization for Use or Disclosure of Protected Health Information

** Please provide to the names and phone numbers of all individuals, clinics, or hospitals where previous or ongoing treatment has taken place.

Patient Name: _______________________________________ Date of Birth: _____________
Patient Phone: _____________________

I hereby authorize the exchange of my heath/mental health information between Healthy Foundations Group and the following individual (s) and/or organizations (s):

Primary Care Doctor: ____
Phone: _________________

Emergency Contact: ____
Phone: _________________

Name of person/provider/facility: ____
Phone: _________________

Name of person/provider/facility: ____
Phone: _________________

Name of person/provider/facility: ____
Phone: _________________

This authorization has no expiration date, except it shall automatically expire upon a minor's 18th birthday. These records/information are for services provided at the facilities indicated. The information may be used/disclosed for treatment purposes both at the time of disclosure and at any time in the future unless otherwise indicated here: __________.

I understand that after the custodian of records discloses my mental health information, the law prohibits the recipient from re-disclosing this information without my authorization. I understand, however, that if my mental health information is disclosed to a recipient who is not covered by federal medical privacy regulations; the information may be re-disclosed without penalty under these federal regulations.

I understand that I have the right to meet with my clinician to inspect my records of mental health information. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. I understand that I have the right to revoke this authorization by sending written revocation to the custodian of records/information named above, as well as to the recipient(s) named above. I further understand that my revocation will be effective upon receipt, except if this release has already been relied upon.

By signing below I, represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_______________________________ _______________________________
Signature & Date Name (please print)