PARTNERS
IN PARENTING

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AUTHORIZATION FOR DISCLOSING AND/OR REQUESTING PROTECTED HEALTH INFORMATION

Client Name: _____ DOB: _____

_____, independent contractor with Partners in Parenting, PC is hereby authorized to: ☐ **REQUEST FROM & DISCLOSE TO** ☐ **REQUEST FROM** ☐ **DISCLOSE TO**

The following recipient who is a:
☐ **Treating/Service Provider** [Indicate Name of Treating Provider Below]
☐ **Other Entity** [e.g. CASA, Judge, Lawyer, CSA Office, School Personnel, Other Payor]
☐ **Individual** [e.g. Family Member]

Name: _____ Agency: _____

Address: _____

Phone: _____ Fax: _____

Description of Information to Request and/or Disclose:

Item(s) for Release:	☐ Verbal Exchange of Information	☐ Psychological Evaluation
☐ Social History	☐ Psychiatric Evaluation	☐Other: _____
☐ Educational Evaluation & Records	☐ Closing Summary	☐Other: _____

Substance Use Information:
☐ **All of My Substance Use Information** ☐ **None of My Substance Use Information**

Or, Only the following Information:	☐ Substance Use Diagnosis	☐ Lab Results of Related Substance Use
☐ Medications for Substance Use	☐ History of Substance Use	☐ Participation in Substance Use Services

Purpose of Request and/or Disclosure:

☐ Assessment	☐ Coordination of Care	☐Court-Ordered Evaluation
☐ Emergency Contact	☐ At Request of Individual	☐Other: _____

I hereby release the above individuals and agencies from all liability and all claims of any nature whatsoever pertaining to disclosure of information contained in my records. I understand that this original release or legible copy is VALID FOR ONE YEAR FROM THE DATE SIGNED unless revoked by me in writing at any time prior to the expiration date.

As the person signing this authorization, I understand that I am giving my permission to the above-named provider to use, disclose and/or request confidential health records until the termination of authorization date. I may refuse to sign the authorization. Treatment, payment, healthcare operations or eligibility are not conditional upon giving authorization. The original or copy of this authorization will be included in my medical record. I also understand that I have the right to revoke this authorization and that my revocation is not effective until delivered in writing to the person who is in possession of my records. I understand that, upon my request, I must be provided a list of entities to which my information has been disclosed.

There is a potential for any information disclosed pursuant to this authorization to be subject of redisclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule.

Person Authorizing Disclosure/Request is ☐ Client ☐ Parent of Minor Child ☐Legal Guardian ☐ Power of Attorney

Client Signature: _____ Date Signed: _____

Client's Personal Representative: _____ Relationship: _____ Date Signed: _____

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.