Felton institute

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Client*:_____ **Date of Birth*:**_____

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and federal law concerning the privacy of such information. **Failure to provide all information marked with an asterisk(*) may invalidate this authorization.**

I hereby authorize an exchange of verbal or written information between **Felton Institute** and the following party: _____

(Name, title, phone number & address of person or organization)*****

for the **purpose of**:*****_____

This information shall be limited to the following types of information – I recognize that if I am disclosing my health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law requires that recipients refrain from re disclosing such information except with my written authorization or as specifically required by law.

- o Discharge Summary
- o Assessment
- o Treatment Plan of Care
- o Physician's Orders
- o Progress Notes
- o HIV/AIDS Treatment
- o Results of Lab Tests
- o Results of Psychological or Vocational Testing
- o Educational Assessment and Behavioral Reports (including school observation & educational testing)
- o Substance Abuse Treatment
- o Other (Specify)_____

My Rights: I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I may revoke this authorization at any time. Revocation must be in writing, signed by me or on my behalf by someone with the legal authority to do so and delivered to Felton Institute. My revocation will be effective upon receipt, but will not be effective to the extent that Felton Institute may have acted in reliance upon this authorization prior to revocation. I have a right to obtain a copy of this authorization. I may not be denied treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Expiration*: This authorization will automatically expire **one year** from the date of execution unless a different end date or event is specified: _____**.**
(date/event)

***** _____ ***** _____ _____

Date **Signature (Client/Patient/Parent/Guardian/Conservator)** Relationship if not Client/Patient

_____ o Interpreter used _____
Witness (Required if Client/Patient unable to sign)

Notes:

*A separate authorization is required to authorize the disclosure or use of **psychotherapy notes**.

If this authorization is for the disclosure of **substance abuse** information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.