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PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

In compliance with CFR§ 164.508 A photocopy of this form will be considered as valid as the original

Name of Client:	**DOB:**
Legal Guardian/Parent Completing form:	
Address/City/State/Zip:	
Phone:	

I hereby authorize PS Kids (Contact Information Above) to:

☐ Obtain information from: ☐ Release Information to:

Name of Person/Company or Organization:	
Address/City/State/Zip:	
Fax Number:	**Phone Number:**

The following documents/information can be released or shared:

- ☐ Therapy Evaluations **Circle:** OT PT ST All
- ☐ Therapy Treatment Notes **Circle:** OT PT ST All
- ☐ Medical and/or Lab Reports
- ☐ Current IFSP or IEP
- ☐ Verbal Consultation
- ☐ Psychiatric/Psychological/Social Work Records***
- ☐ Other: _____

Purpose of Disclosure:

- ☐ Transfer of Therapy Services Other Facility or School
- ☐ Continuing Care
- ☐ At Caregiver Request (not otherwise specified)
- ☐ Legal
- ☐ Other: _____

*****If Psychiatric/Psychological/Social Work Records was checked:**

I understand that this health information may include information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

- ☐ Substance Abuse (alcohol/drug)
- ☐ Mental Health
- ☐ Social Work Records
- ☐

The confidentiality of this record is required under Title 42 of the US Code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

_____ _____
Signature of Client or Legal Guardian Date

This authorization will expire at the time of my last date of service with PS Kids unless otherwise specified here:__ _____

1. I understand that I may revoke this authorization at any time by notifying Molly Hunter, Privacy Officer at the address above, in writing, and this authorization will cease to be effective on the date notified accept to the extent action has already been taken in reliance upon it.
2. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as mental health information.
3. My health care and payment for my health care will not be affected if I do not sign this form.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disability except where disclosure of the information is necessary for the treatment
5. **I understand that I will get a copy of this form after I sign it.**
6. By signing below, I acknowledge that I have read and understand this authorization:

_____ _____
Signature Parent/Legal Guardian or Authorized Caregiver of Client Date

_____
Relationship to Client