BELL CENTER FOR ANXIETY AND DEPRESSION

Authorization Form for Release of Protected Health Information

This form, when completed and signed by you, authorizes the providers at the Bell Center for Anxiety and Depression to release Protected Health Information from your clinical record to the individual or entity you designate; a separate form must be completed for each authorization.

Client's Name: _____ Client's Date of Birth: _____

Address: _____

Telephone: _____ ☐ I authorize the Bell Center for Anxiety and Depression to leave follow-up information/instructions on my voicemail

I, _____, authorize the Bell Center for Anxiety and Depression ("BCAD") to release the following:
(print name)

☐ Billing Information ☐ Consultations ☐ Summary of Record Set ☐ Intake Evaluation
☐ Progress Notes ☐ Entire Record ☐ Treatment Plans ☐ Discharge Summary
☐ Other:_____

Please specify any limitations for this release or any information you do ***NOT*** authorize the Bell Center for Anxiety and Depression to release:

_____

_____

This information is to be released to:

Name: _____ Title/Position: _____

Address: _____

Telephone: _____ Fax: _____

This information is to be used for the following purpose: ☐ Treatment ☐ Attorney ☐ Insurance
☐ Disability ☐ Self *(All that is required as a patient of BCAD if you do not wish to state a specific purpose)*
☐ Other _____

I understand that I may revoke my authorization to disclose/use my Protected Health Information by completing a revocation of authorization. This will not affect any disclosure of information already made. I understand that the Bell Center for Anxiety and Depression does not condition treatment on the completion of this authorization. I understand that PHI disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPAA Privacy Rule. This authorization will expire one year from the date signed or earlier if otherwise stated: _____.

I understand that if my Provider at BCAD believes disclosure of any portion of the medical record to be injurious to me, my provider may refuse to disclose that portion of the medical record to me or another recipient/person in interest, but upon written request, will: make a summary of the undisclosed portion of the medical record available; insert a copy of the summary in my medical record; and permit examination and copying of the medical record by another health care provider who is authorized to treat me for the same condition as BCAD is treating me. I understand that I have the right to select another health care provider.

_____ _____
Signature* Date

_____ _____
Print Client's Name Relationship to Client

*If parents are ***separated*** or ***divorced*** and have ***joint custody*** of the client, then both parents' signatures are *required*.
Only one parent's signature is required if parents are married to each other.

_____ _____
Additional Parent Signature Date

_____ _____
Print Name Relationship to Client