Client # ____________________

Authorization to Disclose Health Information

I, ____ born on this date ____________________
(Name of person whose information is being disclosed)

authorize

____
(Name & address of person/organization **making** the disclosure)

to disclose to

____
(Name & address of person/organization **receiving** the disclosure)

information as described below.

Category of Protected Health Information: I authorize the disclosure of information from the following categories of protected health information (check those that are applicable):

☐ All of my protected health information that includes mental health, substance use disorder, developmental, HIV/AIDS, dental and medical		
Or one or more of the following categories (check each of those authorized):		
☐ Mental health	☐ Substance Use Disorder	☐ Developmental
☐ HIV/AIDS	☐ Dental	☐ Medical

Type of Information/Record: Check the Information/Record type you wish disclosed.

☐Yes ☐No **Entire Record** - includes, but not limited to, assessments, treatment plans/support agreements, progress notes, medication, attendance, test results, behavioral support plans, discharge reports, etc.	
Or only those specified below (Please check Yes or No for each type):	
☐ Yes ☐ No	Assessments / Evaluations including diagnosis, treatment recommendations and associated test results
☐ Yes ☐ No	Treatment Plans / Support Agreements
☐ Yes ☐ No	Progress Reports/Notes on Treatment/ Support including associated test results
☐ Yes ☐ No	Medications Prescribed
☐ Yes ☐ No	Attendance
☐ Yes ☐ No	Behavioral Support Plans
☐ Yes ☐ No	Discharge Summary/Plan
☐ Yes ☐ No	Test Results
☐ Yes ☐ No	HIV/AIDS
☐ Yes ☐ No	Other (must specify):

Other specifics related to information/record to be disclosed (e.g. time period, specific progress notes):

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The means of this disclosure may be written, verbal or electronic.