

# Abundance of Hope, LLC

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## Patient Authorization for Disclosure of PHI (Personal Health Information)

### RELEASE OF INFORMATION

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

I, \_\_\_\_\_, authorize Anna Maith, LGPC to:  
\_\_\_\_\_ send \_\_\_\_\_ receive the following \_\_\_\_\_ to \_\_\_\_\_ from:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR  
PSYCHOTHERAPY NOTES

- |   |  |
|---|--|
| <input type="checkbox"/> Academic Testing Results     | <input type="checkbox"/> Psychological Testing Results             |
| <input type="checkbox"/> Behavior Programs            | <input type="checkbox"/> Service Plans                             |
| <input type="checkbox"/> Progress Reports             | <input type="checkbox"/> Summary Reports                           |
| <input type="checkbox"/> Intelligence Testing Results | <input type="checkbox"/> Vocational Testing Results                |
| <input type="checkbox"/> Medical Reports              | <input type="checkbox"/> Entire Record, except Psychotherapy Notes |
| <input type="checkbox"/> Personality Profiles         | <input type="checkbox"/> Other (Specify) _____                     |
| <input type="checkbox"/> Psychological Reports        |  |

The above information will be used for the following purposes:

- Planning Appropriate Treatment or Program
- Continuing Appropriate Treatment or Program
- Determining Eligibility for Benefits or Program
- Case Review
- Updating Files
- Other (Specify) \_\_\_\_\_

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 & 164) & Title 45 (Federal Rules of Confidentiality of Alcohol & Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if the recipient is not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, & after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, & who will receive the information. I understand

that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to the client:

Self

Parent/ Legal Guardian

Personal Representative

Other (Specify) \_\_\_\_\_

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian/Persona Representative (if applicable) Signature:

\_\_\_\_\_ Date: \_\_\_\_\_

Witness (if client is unable to sign) Signature:

\_\_\_\_\_ Date: \_\_\_\_\_