AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Please provide the following Protected Health Information on:

Name of Person: ______________________________

Date of Authorization: ______________________________

Personal Identifying Information:

Date of Birth: ______________ **SSN:** ______________ **MIS #:** ______________

Client Contact Information *(Address, Telephone Number, E-Mail address, etc.)***:**

Information to be released to:

Description of information to be released:

Assessments, Treatment Plans & Reviews, Progress & Group Notes, Drug Testing Reports and Progress Reports

Purpose of Information: To facilitate treatment

Expiration Date Of Authorization (One Year Or Less): ______________________________

Print Name of Client Representative (If applicable): ______________________________

______________________________ ______________
Signature of Client or Client's Representative **Date**

______________________________ ______________
Signature of Witness **Date**

You have the right to revoke (take back) this authorization. You must make this request, in writing, to the agency you wish to take back the authorization. Some health care providers may choose to not provide services to you or not enroll you in programs if you refuse to provide required information. If you wish to discuss revoking this authorization or refuse to sign this form, you can ask for assistance from DISC Village's, Inc. Privacy Officer who can go over this information in more detail.