Psychological Health Services
Jessica Snyder, LCP
AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A:
Client Name: _____Date of Birth: _____SSN:_____

Parent/Guardian Name: _____Phone #:_____

Address: _____

Section B: I authorize Psychological Health Services: Jessica Snyder, LCP; PO BOX 1014, Holton KS, 66436, (Ph) 785.362.7000, (Fax) 785.362.7100, (Email) jessicasnyder@phs-holton.com to:

Section C: RELEASE the following written information as categorized:

- ☐ ACCOUNT INFORMATION
- ☐ ADMISSION EVALUATION
- ☐ APPOINTMENTS
- ☐ CONSULTATIONS
- ☐ DIAGNOSIS DOCUMENTATION
- ☐ DISCHARGE DOCUMENTATION
- ☐ FINANCE/INSURANCE BILLING INFORMATION
- ☐ LEGAL DOCUMENTATION
- ☐ MEDICATIONS
- ☐ PROGRESS IN TREATMENT
- ☐ PSYCHOLOGICAL EVALUATION
- ☐ SCREENINGS
- ☐ TREATMENT PLANS
- ☐ RECOMMENDATIONS FOR INTERVENTIONS AND CASE PLANNING
- ☐ TREATMENT REPORTS
- ☐ PROGRESS NOTES
- ☐ OTHER: _____

Section D: OBTAIN the following written information as categorized:

- ☐ ACCOUNT INFORMATION
- ☐ ADMISSION EVALUATION
- ☐ APPOINTMENTS
- ☐ CONSULTATIONS
- ☐ DIAGNOSIS DOCUMENTATION
- ☐ DISCHARGE DOCUMENTATION
- ☐ FINANCE/INSURANCE BILLING INFORMATION
- ☐ LEGAL DOCUMENTATION
- ☐ MEDICATIONS
- ☐ PROGRESS IN TREATMENT
- ☐ PSYCHOLOGICAL EVALUATION
- ☐ SCREENINGS
- ☐ TREATMENT PLANS
- ☐ PSYCHIATRIC EVALUATION
- ☐ ALCOHOL AND DRUG TREATMENT
- ☐ EDUCATION PLAN DETAILS

OTHER: _____

Section E: VERBAL COMMUNICATION-By my signature below, I authorize verbal communication with the person or agency listed below in order to coordinate treatment, allow discussion of treatment progress, and discuss relevant concerns or issues regarding the above-named client's treatment.

Section F: RESTRICTIONS- The information indicated will be disclosed unless there are specific restrictions noted here:

_____

Section G:
To/From-Name/Agency: _____Relationship:_____

Phone #: _____ Fax #:_____

Mailing Address: _____

Email Address: _____ **Reminder that email is not a secured method of communication. By providing this you are authorizing communication through this means.**

Section H: THE PURPOSE OR NEED FOR THIS DISCLOSURE (Check all that apply):

- ☐ Evaluation/Treatment Planning
- ☐ School Placement/Assessment
- ☐ Treatment/Case Coordination
- ☐ Legal Proceedings
- ☐ Other:_____

Section I: I understand that under State and Federal confidentiality provisions, only the information specified can be released to the specified person or agency.

Section J: I also understand that PHS cannot ensure that the recipient will maintain confidentiality of this information I have authorized to be released.

Section K: I also understand that this authorization will be honored unless revoked verbally or in writing. Revocation may be made at any time, except to the extent that action has already been taken. To revoke authorization, I need to notify PHS.

Section L: I also understand that this authorization will expire (Select one):

- ☐ One year from this date (date of signature below)
- ☐ OR on the following date: _____
- ☐ OR upon the following specific event (describe):_____

**NOTE: If neither a specific date or a specific event is selected, this authorization will automatically expire 90 days after discharge or 1 year from the date of authorization, whichever comes first.

I understand that if the person or organization authorized to receive this information is not a health care provider or a health plan, or is not otherwise covered under the Federal privacy regulations, the released information may be re-disclosed and will no longer be protected by Federal privacy laws. I understand that certain persons or organizations may not re-disclose treatment information.

Section M: I understand that this authorization is voluntary, and I verify that I have been given the chance to ask and receive answers to questions.

Signature of Client: _____Date: _____

Signature of Authorized Representative (if applicable)_____

Relationship to Client:_____Date: _____

Witness (to signature): _____Date: _____

This information has been disclosed to you from records in which confidentiality is protected by Federal law. Federal regulations prohibit the recipient from making any further disclosure of it without the specified written consent of the person to whom it pertains, or except otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**A photocopy of this authorization shall be considered as valid as the original. **