Authorization to Use, Obtain, or Disclose Protected Health Information

______________________	______________	______________
Client Name	Date of Birth	Date(s) of Treatment

I hereby freely and voluntarily authorize D. Michael Coy, MA, LICSW to:

____ release/disclose my protected health information to: ____ obtain my protected health information from:

Individual, Facility, or Organization	Telephone Number
Street Address	Mobile/ Other Number
City, State, and Zip Code	Facsimile Number

Protected health information to be disclosed or obtained by D. Michael Coy, MA, LICSW:

____ Academic testing results
____ Psychological testing results
____ Intelligence testing results
____ Diagnostic testing results
____ Verbal progress reports
____ Other:____
____ Written summary reports
____ Medical reports
____ Psychological reports
____ Personality profiles
____ Behavior programs
____ Treatment/service plans
____ Clinical/progress notes
____ Psychotherapy notes*
____ Entire record, except psychotherapy notes

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

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:______________________

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and 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 they are 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, and after this consent automatically expires. I have been informed what information will be given, its purpose, and 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. The possible consequence/s of not signing is/are: ______________________________.

This authorization will expire 180 days [ ] following termination of services or [ ] following date of signature, unless another date or condition is specified. Other date or condition specified: ________________________.

Signatures:

______________________________ ______________
Signature of client (if age 13 or older) Date of signature

______________________________ ______________ ______________
Signature of legal guardian or other representative** Date of signature Relationship to client

**If you are the non-parental legal guardian for a minor under age 13 or other representative for the client appointed by the court, please provide a copy of the authorization documentation to verify your right to consent in the client's behalf.