Authorization to Disclose Protected Health Information

Communication between Ascent Psychotherapy Center and Agency/Provider/Facility is important to ensure that you receive comprehensive and quality health care. This form will allow Ascent Psychotherapy Center to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication if necessary.

I, _____, born on _____
(Client Name) (Client dob)
understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

Patient Authorization

❑ I agree to release any applicable mental health/substance abuse information to

Agency/Provider/Facility: _____

Address: _____

Telephone Number: _____

❑ I agree to release only medication information.

❑ I WAIVE NOTIFICATION that I am seeking or receiving mental health services, and I direct you NOT to so notify him/her.

❑ I do not have anyone and do not wish to see or confer with anyone. I therefore WAIVE NOTIFICATION that I am seeking or receiving mental health services.

_____
Patient Signature Date

Patient Rights:

▪You can end this authorization (permission to use or disclose information) any time by contacting: _____

_____

▪ If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
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▪ You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.

▪ You have a right to a copy of this signed authorization. Please keep a copy for your records.

▪ You do not have to agree to this request to use of disclose information.

Information to be completed by Behavioral Health Provider

I saw_____ on _____ for_____
(Client Name) (Date) (Reason/Diagnosis)

Summary:

_____

_____

_____

ATTENTION RECIPIENT:
Notice Prohibiting Re-Disclosure

This information has been disclosed to you from the records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

Provider: Please send a copy of this signed form to the PCP and keep the original in the treatment record.