



**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Work Phone:** (\_\_\_\_\_) \_\_\_\_\_

I, the undersigned patient or legal guardian, hereby authorize verbal  and/or written  information to be released by:

\_\_\_\_\_  
Name of Releasing Facility/Provider

\_\_\_\_\_  
Mailing Address

**To:**

\_\_\_\_\_  
Name of Hospital/Clinician/Third Party Phone

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
Name of Hospital/Clinician/Third Party Phone

\_\_\_\_\_  
Mailing Address

**Information to be released:**

- Psychiatric Evaluation
- Medication Record
- H&P/Lab work
- Psychosocial
- Psychological Testing
- Treatment Planning
- Discharge & Aftercare Plan
- Progress Notes
- Other (specify) \_\_\_\_\_

**Release of information for the following purpose(s):**  Treatment/Consultation  Patient Request  Billing/Claims

Attorney  Other (specify) \_\_\_\_\_

- I understand that the information released may be *(Initial for release of the following information)*: \_\_\_\_\_Mental Health \_\_\_\_\_Substance Abuse \_\_\_\_\_HIV/AIDS information.
- I understand that this authorization is voluntary and that treatment by a Meier Clinics® provider cannot be conditioned on the signing of this authorization.
- I understand there may be a charge, payable in advance, for the copying and conveyance of records released.
- I understand that this authorization can be withdrawn by me in writing at any time. I cannot, however, take exception to actions that have taken place before I withdrew my consent.
- I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected. Meier Clinics® and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that the information which is being released is from records whose confidentiality is protected by state and federal Law.

\_\_\_\_\_  
Patient or Legal Representative (Description/Proof of authority to act for patient must be provided) Date

\_\_\_\_\_  
Witness and Title/Relationship to Patient Date

**Expiration Date: 180 days after signature date**