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- I understand that this authorization can be withdrawn by me in writing at any time.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

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