Authorization to Use and Disclose Protected Health Information (PHI)

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1. **I am completing this form to allow use and sharing of protected health information about:**

   Printed name: _____ Date of Birth: _____

2. **I authorize Janis B. Rice, MA, LPC to use or disclose my treatment and medical records *except for those checked below*:**

   - ☐ Treatment records for physical and/or psychological, psychiatric, or emotional illness
   - ☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, testing records, and behavioral observations
   - ☐ Treatment, recovery, rehabilitation, aftercare plans and other similar plans
   - ☐ Social, family, educational, and vocational histories
   - ☐ Social work assessments, occupational therapy and vocational reports and evaluations
   - ☐ Progress notes
   - ☐ Evaluations and reports of consultants of other health care providers
   - ☐ Information about how the patient's condition affects or has affected his or her ability to work, and to complete tasks or activities of daily living
   - ☐ Billing records
   - ☐ Academic and educational records, including achievement and other test results, reports of teachers' observations, and all other school or special education documents
   - ☐ HIV-related information
   - ☐ Drug and alcohol information
   - ☐ Any other exceptions:
     _____

3. **Dates of care included:** From _____ to _____ [and _____ to _____]

4. **With the following person(s) or organization(s):**

   _____

   _____

   _____

5. **The information will be used / disclosed for the following purpose(s):**

   _____

   _____

6. I understand and agree that this authorization will be valid and in effect until:

   _____ [enter date or event upon which this authorization expires].
   I understand that after that date or event, no additional information can be used or released to the person or organization unless I sign a new authorization like this one.

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7. I understand that I can revoke or cancel this authorization at any time by sending a letter to you. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Janis B. Rice, MA, LPC, nor will it affect my eligibility for benefits.

9. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for those copies or other related services

10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be further disclosed to others and no longer protected by those regulations.

11. I affirm that everything in this form that was not clear to me has been explained, and I believe I now understand all of it.

_____ _____

Signature of client or his or her personal representative **Date**

_____ _____

Printed name of client or personal representative Relationship to client

_____

Description of personal representative's authority

☐ **I acknowledge that I have received a copy of this completed form.**

I, Janis B. Rice, MA, LPC, a mental health professional, have discussed issues in this Authorization Form with the client and/or his or her personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Janis B. Rice, MA, LPC Date