HEART | MIND
THERAPY

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Name: DOB: / /

I authorize ***Dr. Jana Corbett*** to □ obtain information from and □ disclose information to

Name:
Organization:
Address:
Phone number:
Fax:
E-Mail address:

Information to be used/ disclosed consists of mental healthcare information, including:

- □ Full record, including Assessments, Treatment plans and notes
- □ Coordination of care information only □ Assessment only

I understand that additional laws about mental health, alcohol/ drug treatment information and HIV/AIDS may apply. I understand and agree that this information will be disclosed if I check the boxes next to the information.

- □ Mental Health information □ HIV/ AIDS information
- □ Alcohol/ Drug diagnosis, treatment and referral information

I understand that the purpose of this authorization is to facilitate coordination of care between different care providers. I am not required to sign this authorization. If I decline to sign this authorization, it will not prevent me from getting care. I understand that I may revoke this authorization in writing at any time, at which time any information described here may no longer be used or disclosed. Any information that has been used or disclosed prior to the revocation cannot be unshared. I understand that any information used or disclosed as a result of this authorization may be subject to re-disclosure. I also understand that federal and state law may restrict re-disclosure. This authorization expires 60 days after the completion of treatment or closing of the client file respectively.

I have read this authorization and understand it. (You may sign electronically through the patient portal.)

Client signature:_____ Date: _____

Parent/Guardian/Representative signature:_____
Relationship to client: _____