Authorization for Release of Client Health Information

Client Name_____ Phone Number _____

Address_____ Birth Date _____

I hereby authorize that the protected health information regarding the above-named person be exchanged in both directions between Dr. Eddie O'Connor
AND:
Person/Institution_____

Address _____

City_____State_____Zip_____

Phone Number: _____ E-mail*: _____

* _____ (initial here acknowledging and accepting risks of confidentiality via e-mail communication)

Purpose for information exchange (check all that apply):

_____ Improve coaching _____ Improve treatment _____ Coordination of care
_____ Other: _____

Disclosure may include: (check all that apply):

_____ Verbal communication of sessions & treatment planning
_____ Copies of session notes and reports
_____ Medical chart (including but not limited to notes, reports, testing, labs, diagnostics)
_____ Itemized bill

I must check one or more of the following types of health information that I do not want released to the above named Recipients. I understand that if I do not check any of the four (4) following boxes, the health information released to the named Recipients may include any of the following:
_____ Psychiatric/mental health and/or developmental disabilities information
(Parent/guardian co-signature is required for the release of psychiatric information of patients 12-17 years old)
_____ Records of HIV (AIDS/related illness) and/or COVID testing results, diagnosis, or treatment
_____ Alcohol/drug abuse diagnosis or treatment

I also understand that this authorization is subject to revocation/withdrawal by me at any time in writing to Dr. O'Connor except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked, but will expire 1 year after date signed. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information, except in instances defined in the INFORMED CONSENT. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. I understand that there may be copying and/or processing fees associated with this release.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Legal Guardian/Personal Representative Relationship to Client

_____
Witness

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization and the recipients named above that this health information disclosed under this Authorization may be re-disclosed by the recipient to others. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding treatment for drug/alcohol abuse.