

Authorization for Use and Disclosure of Protected Health Information
ENCOMPASS MENTAL HEALTH, LLC

I hereby authorize Encompass Mental Health, LLC to use and/or disclose my protected health information as described below to

Name:	Address:
Phone Number:	Fax Number:
Email Address	

for the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

I understand that:

- 1) THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
- I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
- I may revoke this authorization at any time by notifying Encompass Mental Health, LLC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
- Encompass Mental Health, LLC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Type of Information to Be Disclosed

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Testing Information | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Educational | _____ |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Continuing Care Plan | _____ |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Progress in Treatment | _____ |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> History | _____ |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Billing Records | |
| <input type="checkbox"/> Presence/Participation in Treatment | | |

In addition, I authorize that this will include health information relating to (check if applicable):

- Drug/Alcohol abuse

Expiration:

This authorization will expire 180 days from the date of signing or **(insert date)** _____.

Patient Name: _____

Patient ID #: _____

Signature of Patient or Legal Representative

Date

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

- Parent or guardian of unemancipated minor
 Court appointed guardian
 Executor or administrator of decedent's estate
 Power of Attorney

Signature of Witness

Date