AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
ENCOMPASS MENTAL HEALTH, LLC

I _____ hereby authorize Encompass Mental Health, LLC, 1110 E. 77TH Street, Sioux Falls, SD 57108

- ☐ to disclose the following information from my medical records to the facility listed below,
- ☐ to receive the following information from my medical records from the facility listed below:

Name:		Address:		
Phone Number:		Fax Number:		
Email Address:		Other:		
Allowable Communication:	☐ Phone/Verbal	☐ Email	☐ Mail	☐ Fax

For the following purposes:

☐ Collaboration ☐ Coordination of Care	☐ Obtaining Collateral Information ☐ Referral	☐ To Comply with Court Order ☐ Other: _____

Type of Information to be Disclosed:

☐ Diagnostic Assessment ☐ Psychological or Psychiatric Evaluation ☐ Psychosocial Evaluation ☐ Treatment Plan or Summary ☐ Progress Notes	☐ Current Treatment Update ☐ Presence/Participation in Treatment ☐ Testing Information ☐ Educational ☐ Continuing Care Plan	☐ Progress in Treatment ☐ Demographic Information ☐ Recommendations for the best interests of or care for the client ☐ Other: _____

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

- ☐ Drug/Alcohol Abuse

I understand that:

1) This authorization is voluntary and I may refuse to sign this authorization with affecting my health care or the payment for my health care,
2) 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/or disclosed under this authorization (if allowed by state and federal law. See § 164.524).
3) I may revoke this authorization at any time by notifying Encompass Mental Health, LLC, in writing as set for 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.
4) 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.

Expiration:
This authorization:

- ☐ Will expire after 180 days,
- ☐ Will expire on the following date: _____,
- ☐ Will remain in effect for as long as the client is an active client at Encompass Mental Health.

Client Name			
Signature of Client or Legal Representative		Date	
Printed Name of Client or Legal Representative			
Relationship to Client	☐ Parent or guardian of unemancipated minor ☐ Court approved guardian ☐ Executor of administrator of decedent's estate ☐ Power of attorney		
Signature of Witness		Date	