Authorization for Release of Protected Health Information (PHI)

My health record is private and is known under the law as "Protected Health Information (PHI)." By completing and signing this form, I, or my legal representative, agree to allow Heights Anxiety and Depression Center to share my PHI with the people or companies listed below.

1. **My Information:**

Name:	D.O.B.:
Address:	

2. **Heights Anxiety and Depression Center can share/receive my PHI with the following people or companies:**

Name of Organization/Person:	**Phone:**	**Fax:**
Address:	**Email:**	

Information to be disclosed (Type of Request) **Please check at least one:**

☐ Entire record ☐ Psychiatric Initial Evaluation ☐ Progress Notes

☐ Therapy Notes ☐ Labs ☐ Billing Reports

☐ Verbal Consent – Relationship to Patient: _____

☐ Other (Please Specify) _____

Purpose of Disclosure:

☐ Continuity of Care ☐ Patient/Guardian request ☐ Disability/ FMLA

☐ Attorney Requests ☐ Other (Please Specify) _____

Right to Terminate or Revoke Authorization: You have the right to revoke or terminate the authorization of your PHI in in writing to Heights Anxiety and Depression Center. Potential for Re-Disclosure: Information that is disclosed for this authorization might be disclosed again by the person or organization in which the information is intended for. Heights Anxiety and Depression Center cannot ensure protection of your PHI once it is disclosed to another party. Individual Rights: You have the right to review or copy the information used or disclosed under this authorization. You can refuse to sign this authorization, if you do not agree with what information is being disclosed.

3. **This form will be valid for 1 year unless a shorter time period is listed.**

(MM/DD/YY) TO (MM/DD/YY)

Name: Date:

Signature:

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