morrison
child & family services

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

This form may not be changed once it is signed

I, _____, (birth date) _____ authorize
(client if over 14 **OR** guardian of client listed below) (of client if 14 or older)
Morrison Child and Family Services to *disclose to* ☐, *receive from* ☐ ***(name of person or agency):***
_____ address _____
phone # _____ a copy or verbal exchange of the specific health/mental health information **initialed** below regarding (name of person served) _____
(birth date) _____ consisting of: (**Please initial choices**)

____ Therapy/case notes _____ Medication used in treatment ____ Psychiatric reports
____ Progress reviews _____ School Reports ____ Treatment Plans
____ Medical reports _____ Psychological Reports ____ Assessments
____ Results of court proceedings (other than expunged records) ____ Discharge Summary
____ Other: (specify) _____

The purpose or need for the information is (**initial each as relevant**):
____ Diagnosis/Evaluation ____Education Planning ____ Coordination of Services
____ Treatment Planning/Ongoing Treatment ____ Other (please specify) _____

If the information to be disclosed contains any of the types of information listed below, additional laws relating to the use and disclosure of the information may apply. *I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.*
_____ HIV/AIDS information _____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed related to this authorization may be subject to redisclosure through court order and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, and drug/alcohol diagnosis, treatment, or referral information.

Instructions: *Working cooperatively with other agencies and service providers can be a very important part of how we help you and your family. Please seriously consider the option you have to authorize this release. You do not need to sign this authorization. Refusal to sign will not affect your ability to receive health care services or payment for services. But if you refuse to sign this authorization we will be unable to share information with others.* If you are coming to us solely for the purpose of providing health information to someone else then this authorization is necessary to make that disclosure.

You may stop this authorization in writing at anytime. If you stop your authorization, the information described above may no longer be used or disclosed for the purpose described above. The only exception is when Morrison has already taken action based on the authorization or the authorization was obtained as a condition of your insurance coverage.

To stop this authorization, please send a written statement that you are stopping this authorization. Please send it to the Program Director of the Morrison program where you receive services.

I have read this authorization and I understand it. Unless stopped, this authorization expires in 365 days from the date of the signature below unless otherwise specified for less number of days here (# of days: _____)

_____ _____
individual OR guardian of individual date

_____ _____
staff facilitating this release of information date