Morrison Child and Family Services
AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION

Name of Client: _____ DOB: _____

Sharing and receiving information with other service providers helps us provide you and your family with comprehensive, quality services. You have the right to refuse to authorize the sharing and receiving of information between your providers and others. Please know that you have options when considering whether to authorize this release. Refusal to sign will not affect the services you receive and will not prevent your insurance company from paying for services. If you choose not to sign this authorization, we will be unable to share information.

I, _____, authorize:
(Client if 14 yrs. or over OR legal guardian of client listed)

_____
(Name of person / entity / facility disclosing information)

_____ _____ _____ _____
(Address of person / entity) (City) (State) (Zip Code)

to exchange or provide specific health/mental health information with Morrison Child and Family Services. The information exchanged will include the following:

☐ Mental Health Assessments/Evaluations	☐ Treatment/Service Plan	☐ Therapy/Case Notes	☐ Psychiatric Evaluations
☐ Psychiatric Medication Notes	☐ Medications Used in Treatment	☐ Drug/Alcohol Assessments	☐ Urinalysis Test Results
☐ Lab Test Results	☐ Discharge/Termination Summary	☐ Other:	

If the information to be disclosed contains any of the types of information listed below, additional privacy laws 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. **(Place initials in spaces below)**

_____ Mental Health Information

_____ Drug/Alcohol Information

_____ HIV/AIDS Information

_____ Genetic Testing Information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and 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, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

The purpose or need for this information is:

- ☐ Diagnosis/Evaluation
- ☐ Education Planning
- ☐ Coordination of Services
- ☐ Treatment Planning
- ☐ Legal
- ☐ Other, specify: _____

CLIENT ACKNOWLEDGEMENT

- I was given the chance to ask questions about this form.
- I understand what this form means, and I approve of the disclosures or releases listed.
- I understand that state and federal law protect information about services I receive from the listed agency, business, organization or individual.
- This authorization is valid for one year from the date of signing unless otherwise specified below.
- I understand that I can revoke (cancel) this authorization at any time and revocation (cancellation) will not apply to any information already disclosed or released. Except for drug and alcohol information, either I or a person legally authorized to act on my behalf must submit the cancellation request in writing to the Morrison Child and Family Services Staff or Privacy Officer. Oral or written notification of the cancellation of authorization for drug and alcohol information shall be accepted.
- I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, or referral information without authorization by me or a person legally authorized to act on my behalf.
- I understand that information that is not subject to restrictions on re-disclosure may be re-disclosed, and that the information that is re-disclosed may no longer be protected by state or federal law.
- I understand someone may need to contact me about this form to confirm my identity or to collect additional information.
- I am signing this authorization of my own free will.

I have read this authorization and I understand it. Unless stopped, this authorization expires in 365 days from the date of signature below unless specified for a fewer number of days or discharged from services. (#days: _____)

_____ _____

Client Signature (if 14 years or over) Date

_____ _____

Legal Guardian Signature Date

_____ _____

Staff Signature Date