

Authorization to Use and Disclose Protected Health Information

1. I am completing this form to allow the use and sharing of protected health information about: Name: _____ Date of birth: _____

2. I authorize this person or organization: Sven Schild, Ph.D.

3. To disclose or use the following information:
 - Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness.
 - Admission and discharge summaries.
 - Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
 - Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
 - Social, family, educational, and vocational histories.
 - Social worker assessments, occupational therapy and vocational reports and evaluations.
 - Evaluations and reports of consultations.
 - Information about how the patient's condition affects or has affected his or her ability to work, and to complete tasks or activities of daily living.
 - Billing records.
 - Academic and educational records, including achievement and other test results, reports of teachers' observations, and all other school or special educational documents.
 - Police, probation, and court reports.
 - Department of Social Services reports.
 - Department of Rehabilitation information.

4. To this person or organization: _____.

5. The information will be used/disclosed for the following purposes: _____
_____.

6. I understand and agree that this Authorization will be valid and in effect until the following expiration date: _____. I understand that after that date, no more of this information can be used or released to the person or organization unless I sign a new Authorization form.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter requesting the revocation of this consent. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or agency listed in # 2 above, nor will it affect my eligibility for benefits.

9. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for copy or other services such as writing letters for Court or for other professionals.

10. I understand that if the person or entity that receives the information is not a health-care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by those regulations.

11. I understand that the professional or agency listed in # 2 above will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.

12. I affirm everything in this form that was not clear to me has been explained and I believe I now understand all of it.

Signature of client or guardian

Date

13. I, a mental health professional, have discussed the issues above with the client and/or his or her guardian. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Professional

Date