Authorization for Release of Information

Name: _____   **Date of Birth:** _____

Address: _____   **City, State, Zip:** _____

☐ **I authorize Playful Connections Therapy Center to release information to:** | **AND/OR** | ☐ **I authorize the Playful Connections Therapy Center to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

_____
Name of Provider or Facility

_____
 Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

PURPOSE OF THIS REQUEST: (check one) ☐ **Healthcare**   ☐ **Insurance Coverage**   ☐ **Personal**   ☐ **Other**

TYPE OF RECORDS AUTHORIZED: ☐ **Psychiatric/Psychological Evaluation and/orTreatment**
☐ **Medical Records**

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **Assessments**   ☐ **Progress Notes**   ☐ **Laboratory Test Results:** _____

☐ **Diagnostic Impression**   ☐ **Discharge Summary**   ☐ **Treatment Plans**

☐ **Treatment Summary**

☐ **Other:** (please describe)_____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**
    ☐ When the requested information has been sent/received.
    ☐ 90 days from this date.   ☐ Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.
    My authorization will expire:
    ☐ When I am no longer receiving services from Playful Connections Therapy Center.
    ☐ One year from this date.   ☐ Other: _____

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.
- I may cancel this authorization at any time by submitting a *written* request to Playful Connections Therapy Center, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of Client or Parent/Guardian: _____ Date: _____

Relationship to Client: ☐ Parent   ☐ Legal Guardian ☐ Other: _____

Patient or Representative has been provided a copy of this authorization: _____
                                             Staff member providing copy

4/03/2012