Authorization to Disclose Protected Health Information

As the person who is the subject of the protected health information, I request and authorize:

Perspectives Therapy Services, LLC

to disclose to and/or obtain information from:

Name of person or organization	Phone
Address	Fax

Description of Information to be Disclosed (Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Presence/Participation in Treatment
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
_____Dates of Service with Corresponding Charges
_____ Financial balances (able to accept payment from the authorized party identified on this form)
_____Other_____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to my provider at the respective office where I render services. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on this authorization.

Expiration
Unless revoked earlier, this authorization expires 365 days from the date of signature.

Conditions
I understand that my signature on this authorization has no relationship to my ability to receive treatment, payment, enrollment or eligibility for benefits.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

A copy of this authorization will be provided to you upon request.

Print Name of Client	Date of Birth
Signature of Client	Date
Signature of Parent, Guardian or Personal Representative	Date

If you are signing as a personal representative, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

Signature of Staff Witness	Date