



Authorization

I hereby authorize release of my confidential mental health information as described below. I understand that this authorization is voluntary. I understand that if the organization/person authorized to receive the information is not a health care provider, a mental health care provider, or a health plan, the released information may no longer be protected by the federal privacy regulations

1. Name:

2. Date of Birth:

3. This authorization allows _____ to receive and provide information to _____ for the purpose of continuity and coordination of care.

4. This release of information will be used solely for the purpose of treatment planning and coordination of care unless specifically noted as follows:

5. This authorization is valid for (choose one):

One year

Through the duration of mental health treatment at Creekside (not to exceed two years)

Other chosen duration (please indicate duration in text box below; may not exceed two years)

Other chosen duration (if applicable):

6. I understand that I may revoke this authorization at any time in writing, except as to information released before the receipt of this revocation.

yes

no

7. I understand that my mental health care will not be denied if I refuse to sign this authorization.

yes

no

8. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections.

yes

no

9. I understand that I am entitled to a copy of this authorization and may print this form if I desire a copy.

yes

no

Signature

Date