FARRAR & ASSOCIATES MENTAL HEALTH

3301 North Ballard Road, Suite C Appleton, WI 54911 tel: 920.841.8326 fax: 833.283.7571 contact@farrarmentalhealth.com

Authorization for the Disclosure of Health Information

Photocopy or facsimile of the original authorization will be considered as valid as the original

Patient : _____ DOB: _____

Authorizes Farrar and Associates Mental Health to:

- ❑ Request from
- ❑ Send to
- ❑ Exchange with

_____
Name

_____
Office or Relationship to Patient

_____
Phone Number

Covering the period of care from:

❑ All dates of service ❑ Specific Dates: _____ to _____

Information to be released: (*Check all applicable categories*)

- ❑ Patient Care Status
- ❑ Diagnosis
- ❑ Treatment Plans
- ❑ Medications
- ❑ Psychological Testing Results
- ❑ Payments / Billing
- ❑ Progress Notes
- ❑ Alcohol/Drug Treatment/Evaluation
- ❑ Scheduling

Other information to be **released:**_____

Any information to be **excluded:** _____

Purpose for Requesting Information:

- ❑ Coordination of Care
- ❑ Legal
- ❑ Insurance/Work Comp
- ❑ Personal / Self
- ❑ Emergency Contact/Support
- ❑ Other _____

I understand that if the person(s) and/or organization listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to inspect or copy health information to be used or disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the office. **Right to Receive a Copy of this Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I may be provided with a signed copy of the form upon request. **Right to refuse to sign this Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and or organization(s) listed above who I am authorizing to use/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw this Authorization** - I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the office. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above already made in reference to this authorization.

Expiration date: This authorization is good until this date: _____ **OR**

- ❑ In one year
- ❑ It does not expire

_____	_____	_____
Print Patient Name	**Patient Signature (ages 14 and older)**	**Date**
_____	_____	_____
Print Parent/Legal Guardian Name	**Parent/Legal Guardian Signature**	**Date**

(Please complete this line if the client is less than 18 years old or has a legal guardian)