

Reflections and Self Growth
Authorization to Disclose or Obtain Protected Health Information



REFLECTIONS AND SELF GROWTH
REFLECT, THRIVE AND GROW

Client Information

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Authorization to Release or Obtain Information

I hereby authorize [Practice/Therapist Name] to:

Release information to

Obtain information from

Recipient/Source of Information:

Name/Organization: _____

Address: _____

Phone: _____

Email/Fax (if applicable): _____

This information is being released for the following purpose(s):

Coordination of care

Continuity of treatment

Legal purposes

School/Work accommodations



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Personal request

Other: _____

The information to be disclosed includes:

Diagnosis and treatment summary

Progress notes

Attendance records

Psychological evaluation or assessments

Medication history

Entire mental health record

Other: _____

Sensitive Information Authorization (if applicable):

Substance use/abuse treatment

HIV/AIDS status

Psychiatric hospitalization

This authorization will expire:

On the following date: _____

Upon the completion of the intended purpose.

Client Rights

I understand that:

- I may revoke this authorization at any time by providing a written notice, except where action has already been taken based on this authorization.

- My mental health records are protected under federal and state confidentiality laws.
- Information disclosed under this authorization may no longer be protected if shared with a non-covered entity.
- Refusal to sign this form will not affect my right to treatment.

Acknowledgment and Consent

By signing below, I acknowledge that:

- I have read and understand the terms of this authorization.
- I voluntarily authorize the release or receipt of my information as described above.

Client Signature: _____



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Date: _____

Parent/Guardian Signature (if applicable): _____

Date: _____

Therapist Signature: _____

Date: _____