WESTSIDE CHRISTIAN COUNSELING CENTER

Authorization for Use and/or Disclosure of Protected Health Information

Client Name:	Date of Birth:
	Social Security No:

I hereby authorize _____ (therapist) to:

□ Disclose information to □ Request information from □ Exchange information with

Name:

Address:

City: State: Zip Code:

Phone: Fax:

Check and initial type of information authorized to be requested or disclosed:

□ Admission Intake □ Psychological Evaluation Report □ Treatment Plan

□ Summary of Treatment □ Progress Notes □ Entire Record (except billing)

□ Other_____

All of the records authorized above may be requested or disclosed unless restrictions are specified here:

_____

I understand that this information will be used for the purpose of:

□ Evaluation □ Treatment □ Case Coordination □ Follow-up Care

□ Other (specify):_____

This authorization shall remain in effect until _____(date) at which time this authorization to disclose the identified PHI expires, but not later than one year from the date listed above. If this item is left blank, the authorization shall remain effective for 365 days after the date listed below.

In signing this authorization, I understand and acknowledge the following (initial in the space provided):

_____ I understand that this authorization is voluntary and that I may refuse to sign it.

_____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

_____ I understand that I may revoke this authorization at any time by notifying the Company in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance of this authorization. Any notice of termination must be sent to the Privacy Official, 520 S. Holland Suite 512, Wichita, Kansas 67209.

_____ I understand that, unless otherwise revoked, this authorization herein has been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

I, the undersigned, do hereby swear that I am the above-mentioned patient or a legal representative of the above mentioned patient. I have read and understand the above information.

Signature of Patient/Legal Representative	Date	Printed Name of Legal Representative & Relationship to Patient	
Therapist Signature	Date	Therapist Signature	Date