

Big Sky Family Therapy

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Family Systems Trauma Therapy
Advanced Certificate



DIR/Floortime
Advanced Certificate

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION

I hereby voluntarily authorize Big Sky Family Therapy to release and exchange copies of information from the medical records of the following client:

Client's Name:

Date of Birth:

TO: Provider name:

Provider address:

Phone number:

Fax number:

Information released for the following purposes:

My personal record Communication with other health care providers as needed

Other (please describe):

Information released for how long? One Year OR Date range: from _____ to _____

Information to be released:

All medical records Physician notes Hospital records Physician notes
Rehabilitative therapy (PT, OT, Speech) Psychological/psychiatric/counseling records

Other (specify):

I understand that the records released may contain the following information, which is protected by State and/or Federal law, and I authorize you to release this information (please check all those that apply):

Mental health treatment Drug and alcohol abuse AIDS/HIV related information

I have read and understand the following and indicate with a check mark:

This authorization expires one year after I sign it, or on this date.

The time period stated here may exceed one year only in certain situations specified by law. I may revoke this authorization at any time or by notifying Big Sky Family Therapy in writing.

The authorization will cease to be effective on the date notified. This will not apply to records that have already been released.

The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specifically protected information.

Once the records are released, Big Sky Family Therapy cannot prevent them from being released to a third party. There may be a fee for releasing these records.

To be valid, this authorization must be filled out completely and signed. A copy is valid if it has not been altered.

If I do not sign this authorization, my healthcare and payment for my healthcare will not be affected; and will not jeopardize my right to obtain present or future treatment, except where disclosure of the information is required for treatment.

Signature of Client/legal guardian:

Date:

Relationship to client: Parent Guardian Power of Attorney

Reason client cannot sign: Minor Disability Other: