

The Pisgah Institute for Psychotherapy & Education, P.A.

158 Zillicoa Street, Asheville, NC 28801

(828) 254-9494. Fax (828) 254-0161 or (828) 250-0890

Mental Health Authorization for Disclosure of Protected Health Information (PHI)

Patient Name: _____ Date of Birth: ____/____/____

Patient Address: _____ SSN: ____ - ____ - ____

Street/P.O. Box-Apartment #

City

State

Zip Code

I understand that this authorization is probably for disclosure of PHI for purposes other than treatment, payment, or health-care operations. I understand that The Pisgah Institute is NOT required to obtain authorization to share my PHI for most purposes related to treatment, payment, or health-care operations. (See your copy of our Notice of Privacy Practices.) I understand that I have the right NOT to authorize release of my PHI for purposes other than treatment, payment, or health care operations. I understand that if PHI disclosed pursuant to this authorization is redisclosed by the recipient, it would no longer be protected by the HIPAA Privacy Rule. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol or other substance abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information. I also understand that if I refuse to sign this authorization for purposes other than treatment, payment, or health-care operations, my refusal to sign will not affect my ability to obtain treatment, payment for services, or information about my eligibility for benefits from any health-care provider or health plan named herein. However, if a service is requested by non-treatment provider (e.g., an insurance company) for the sole purpose of creating health information (e.g., about my eligibility for insurance coverage), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I authorize (Provider Name) _____

Address _____

Street/P.O.Box

City

State

Zip Code

To send PHI to (who/which is to receive PHI): _____

(Myself or name of healthcare provider, insurance company, attorney, or other recipient)

Address _____

Street/P.O.Box

City

State

Zip Code

For the purpose of (Check):

Coordination of care

Legal/court matter

Personal use

Other purpose (specify) _____

I authorize the following PHI to be disclosed (Check):

Complete record

Intake/discharge only

Progress notes only

Consult report only

Other PHI (specify) _____

This authorization may be relied upon when transmitted by fax (Check):

Yes

No

I further authorize the PHI to be sent by fax (Check):

Yes

No

I agree to hold The Pisgah Institute harmless if any PHI transmitted by fax does not reach the authorized recipient (Check):

Yes

No

I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon, and this authorization shall remain in force for one year or until (Date): _____, 20____

Signature of Patient, Parent (for minor or child), Legal Guardian, or Authorized Representative

Date

Signature of Witness (Required)

Date