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: ____/____/____

I understand that The Pisgah Institute is NOT required to obtain authorization to share my Protected Health Information 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 Protected Health Information for purposes other than treatment, payment, or health care operations. I understand that if Protected Health Information disclosed pursuant to this authorization is redisclosed by the recipient, it may 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 unless I refuse permission to release information about HIV/AIDS or substance abuse. I also understand that if I refuse to sign this authorization for purposes other then treatment, payment, or health-care operations, my refusal to sign will not affect my ability to obtain treatment 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. Release of my Protected Health Information may be significantly delayed if I specifically deny authorization to release information on HIV/AIDS or substance abuse because of the need to eliminate such information from my medical record before releasing it to the requestor.

I authorize (Provider's Name) _____

Phone _____ **Fax** _____

Address _____
Street/ P.O. Box City State Zip Code

To send Protected Health Information to: _____
(Myself or name of healthcare provider, insurance company, attorney, or other recipient)

Phone _____ **Fax** _____

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):

- ☐ Transmission of Complete record
  - **If you select complete record, you must also select below:**
    - ☐ HIV- and/or AIDS-related information
    - ☐ Substance-use information
- ☐ Transmission of Intake/discharge only
- ☐ Transmission of Progress notes only
- ☐ Transmission of Consult report only
- ☐ Verbal Communication only (includes in-person, telephone, and/or electronic communication)
- ☐ Other Protected Health Information (specify) _____

I agree to hold The Pisgah Institute harmless if any Protected Health Information 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____

I understand that a request for medical records may take up to 30 days for processing.

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

_____ _____
Signature of Witness (Required) Date