**AUTHORIZATION FOR THE RELEASE AND RECIPEROCAL EXCHANGE**

**OF PROTECTED HEALTH INFORMATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name Date of Birth

This form, when completed and signed by you, allows the exchange of protected health information between PEACE Ranch and the person or agency you designate below. This authorization is not a blanket wavier: it allows for specific information to be shared with specific people for a specific purpose, as indicated by you below.

THE PURPOSE OF THIS DISCLOSURE IS:

\_\_\_\_ To assist with treatment \_\_\_\_ To make a referral \_\_\_\_ To allow for billing

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am authorizing PEACE Ranch and the PERSON/AGENCY below to share protected health information about ME/MY CHILD:

Person/Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am authorizing only the following information to be released:

Client Initials Information

\_\_\_ Psychological and/or psychiatric evaluation and diagnosis

\_\_\_ Clinician or case manager treatment plan and/or service notes

\_\_\_ Family history regarding symptoms and treatment

\_\_\_ Medication information

\_\_\_ Verbal exchange regarding client evaluation and treatment

\_\_\_ Intake and Discharge Summaries

\_\_\_ School conduct information

\_\_\_ Education achievement information

This authorization will remain in effect until one year from the date authorized. I may revoke this authorization at any time by giving written notice. This authorization is fully understood and is voluntarily made on my part.

I understand that information used or disclosed pursuant to the authorization may be subject to re- disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of client or client’s legal representative Date