Authorization: PHI

PAUL MYERS, Ph.D., LLC
LICENSED PSYCHOLOGIST

Authorization to Use and Disclose Protected Health Information

I authorize Paul Myers, Ph.D., LLC to receive and disclose personal health information described below regarding:

Client Name:

Consisting of: *(Description of information to be used or disclosed)*

From/To: *(Circle one if it is one direction) (Name and address of person to exchange information)*

For the purpose of:

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Alcohol/drug diagnosis, treatment, or referral information
_____ Mental health information
_____ Genetic testing information

I understand that the information used or disclosd pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under federal law. However, I also understand that federal and state law may restrict re-disclosure of HIV/AIDS information, mental health information, alcohol/drug diagnosis, treatment, or referral information, or genetic testing information.

You do not need to sign this authorization. Refusal to sign this authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to Paul Myers, Ph.D., LLC.

Signature

I have read this authorization and I understand it. Unless it is revoked, this authorization expires on: _____ (Date)

By: _____ Date: _____

(Signature of Client or Legal Representative of Client)

Witness: _____ Date: _____