Authorization to Use and Disclose Protected Health Information

I am completing this form to allow the use and sharing of Protected Health Information about:

Printed Name: _____ Date of Birth _____

I authorize this person or organization:

- ☐ Colleen Lynch, LCSW 102 Point East Dr, Nashville, TN 37216 (615) 969-4575 fax 855-491-1099
- ☐ Cathy Nugent, LPC MHSP 102 Point East Dr, Nashville, TN 37216 (615) 540-4169 fax 855-491-1099

To (initial all that apply) ☐ Obtain ☐ Release ☐ Communicate about

The following information (initial all that apply):

- ☐ Medical history & treatment
- ☐ Diagnosis
- ☐ Initial Assessment & Recommendations
- ☐ Progress notes or case notes
- ☐ Psychological Assessments &/or evaluation
- ☐ Psychiatric Assessments &/or evaluation
- ☐ Psychosocial Assesments & History
- ☐ Discharge Summary
- ☐ Other (please specify): _____

_____

OR ☐ *Authorization for Psychotherapy Notes **ONLY** (please note that if you use this authorization form for psychotherapy notes, you must not use it as authorization for any other type of protected health information).

✳ HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here: **DO NOT RELEASE THESE** Signature:_____

This information is to be used for:

☐ continuation of care ☐ evaluation of mental health treatment ☐ other: _____

I authorize the indicated provider at Inglewood Therapy to use and/or disclose the information described above

TO: _____ **During the effective period of (check one)**

address _____ ☐ TO_____FROM_____ OR

phone _____ fax_____ ☐ all past, present & future dates

- I understand that this authorization will be valid for one year as long as I am a client. If my treatment ends, this authorization is no longer valid.
- I understand that I can revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. This request must be received in writing.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Inglewood Therapy, nor will it affect my eligibility for benefits.
- I understand that once the information about me leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. I understand that at that point my information may no longer be protected by HIPAA.
- I understand that a copy of this release is as valid as the original and that I have a right to a copy of this notice
- I affirm that I have a clear understanding of the contents and purpose of this form.

_____ _____
Signature of client (or parent/legal guardian) Date

_____ _____
Printed name of client (or parent/legal guardian) Relationship if guardian

_____ _____
Witness Signature Date