ViewPoints
Psychotherapy Services LLC

BELIEVE. ACHIEVE. BECOME.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Parent/Legal Guardian: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

I, _____, authorize **ViewPoints Psychotherapy Services, LLC** and (name of designee below):

- ❑ Name: _____ Facility: _____ Relationship: _____

  Address: _____ Phone Number: _____

- ❑ Name: _____ Facility: _____ Relationship: _____

  Address: _____ Phone Number: _____

- ❑ Name: _____ Facility: _____ Relationship: _____

  Address: _____ Phone Number: _____

To exchange and release information as specified below with designees specified above.

INFORMATION TO BE EXCHANGED AND RELEASED:

MEDICAL RECORD(S):

- ❑ All pertinent MEDICAL records
- ❑ All pertinent BILLING records
- ❑ Limited to:
  - Psychotherapy Notes
  - Psychiatric Notes
  - Alcohol/Drug Abuse Evaluation & Summary
  - Psychological Testing
  - Educational Testing
  - Treatment Plan
  - Other: _____

RECORD FORMAT (CHOOSE ONE):

- ❑ E-mail E-mail Address: _____
- ❑ Paper
- ❑ Verbal Communications

PURPOSE:

- ❑ Self, at my request
- ❑ Continuing Medical Care
- ❑ Care Coordination
- ❑ Legal Representation
- ❑ Other: _____

DATES OF SERVICE BEING REQUESTED

From: _____ To: _____

Any person or facility you would not like to disclose information with: _____

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RECORDS TO BE PICKED UP BY / OR MAILED TO:

Company/Person/Facility: _____

Phone number: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/ Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that ViewPoints Psychotherapy Services will not deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. ViewPoints Psychotherapy Services' Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

Unless I revoke this authorization earlier, it will expire 1 year from the date signed or as specified: _____

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release ViewPoints Psychotherapy Services, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian Date

In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.

_____ _____ _____
Signature of Legal Representative Date Relationship to Patient or Description of Authority to Act for Patient