Costa Clinical Psychology, LLC

Standard Mental Health Release of Information

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)**

Patient Name_____ **DOB**_____

****1. Authorization****

I authorize_____to use and disclose
the protected health information described below to/with:_____.

****2. Purpose****

The purpose for the release of this information is: _____.

****3. Effective Period****

This authorization for release of information covers the period of healthcare from: _____ to _____.
(period of time under provider's care)

****OR**** □ all past, present, and future periods.

****4. Extent of Authorization****

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, Psychotherapy Notes, Communicable Diseases, HIV or AIDS, and treatment of Alcohol or Drug Abuse).

****OR**** b. □ I authorize the release of my complete health record with the exception of the following information:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify): _____

5. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative

_____ _____
Printed name of patient or personal representative and his or her relationship to patient

_____
Date