EVERGREEN
behavioral health

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## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

**Patient's Name:**_____ **DOB**:_____

- With my signature below, I authorize _____ and Evergreen Behavioral Health to obtain and disclose information to:

  Name:_____

  Address:_____

  _____

  _____

  Phone: _____ Fax: _____

- Unless otherwise stated, the mental healthcare information below will be used/disclosed/communicated for the purpose of coordination of care.

  __ Assessment/Evaluation __ Treatment Plan __ Progress Notes __ Coordination of Care Info

  __ Other: _____

I understand that additional laws about mental health, HIV/AIDS, genetic, and alcohol/drug treatment information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space.

Initial: _____Mental health information

Initial:_____Drug/alcohol diagnosis, treatment, or referral information

Initial:_____ HIV/AIDS information

Initial:_____Genetic testing

Other Information:

I understand that I am not required to sign this authorization. If I refuse to sign this, it will not prevent me from getting mental health or drug/alcohol treatment at Evergreen Behavioral Health. The only exception is if the services I am seeking are only for providing health information to someone else and this authorization is needed to make the disclosure.

I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed for the reasons described here. If Evergreen Behavioral Health has already used or disclosed information, it cannot be undone. To revoke this authorization, I can request the form from my provider and return the completed form to them.

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

Unless revoked, this authorization expires 60 days after the completion of treatment or:_____

I have read this authorization and understand it.

**Patient signature**:_____ **Date**:_____

**Parent/Guardian/Representative**:_____ **Date**:_____

**If Personal Representative, Print Name**:_____

Relationship to patient: __Parent __Legal guardian __Power of Attorney/Healthcare __Other