Behavioral Health Program

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AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____
Patient Name **Date of Birth**

I authorize Highland Pediatrics to use, disclose, or obtain my/my child's protected health information to/from:

Name: _____

Organization: _____

Address: _____
Street **City/Town** **State** **Zip Code**

The specific purpose of this use/disclosure is for coordinating care. The specific information to be used, disclosed, or obtained is as follows:

___ Mental health Records	**___Discharge Summary**	**___History and Physical Examination**
___Psychiatric/Psychological Evaluation	**___Medical Evaluation**	**___Treatment Plan**
___Complete Medical Record	**___Educational Records**	**___Other**

I understand that the best possible outcomes are achieved only through a collaborative approach to treatment. I acknowledge that I have signed this **Authorization** voluntarily. I acknowledge that I have the right to revoke this **Authorization** at any time by submitting my request in writing to **Highland Pediatrics**, except to the extent that others have acted in reliance upon this **Authorization.** I understand that I cannot revoke authorization of information that has been previously used, disclosed, or obtained under this **Authorization**. I understand that this **Authorization** will expire at the end of treatment unless it has been previously revoked in writing.

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Print Name Witness

_____
Relationship to Patient