**Catherine Samson, PMHNP, LLC** *Psychiatric Mental Health Nurse Practitioner*

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## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Client Name_____ DOB ____/_____/_____
Street Address: _____
City, State, Zip Code: _____
Telephone Number: _____

**I authorize Catherine Samson, PMHNP, LLC**

**Check appropriate box(es) and initial and give complete name and address:**

___ □ **To give health records to:**
___ □ **To receive health records from:**
___ □ **To verbally exchange health information with:**

Name: _____
Street Address: _____
City, State, and Zip Code: _____
Telephone: _____
Fax Number: _____

□ **For the purpose of continuing care or** □**:**_____
□ **All information in chart** □ **Specific information to be released:**_____

By **initialing** the spaces below, I specifically authorize the release of the following health information, if such information exists:

___Mental health related information
___Drug/alcohol diagnosis, treatment or referral information
___HIV/AIDS related records
___Genetic testing information

As indicated below, the authorization for release extends to the care and treatment the client received during:

___ □ All dates of service
___ □ Service between _____ and _____

**Required Statements**:
This authorization will expire in one (1) year or upon (insert date or event) _____ .

I may revoke this authorization in writing by presenting my written revocation to Catherine Samson, PMHNP, LLC.

I understand that the revocation will not apply to information that has already been released in response to this authorization.

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I may inspect or copy any information used and/or disclosed under this authorization. Catherine Samson PMHNP, LLC is not responsible for the cost of copies.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing information under federal or state law.

_____ _____
Signature of Client Date

_____ _____ _____
Signature of Personal Representative Date Relationship to Client

*If patient is 14 years or older form must be signed by patient