Understanding Minds
PSYCHOLOGICAL SERVICES

Authorization for Release of Protected Health Information

Client Identification:

Printed Name: _____ Date of Birth: _____

Address: _____Telephone: _____

I authorize Shanon Harlow LLC DBA Understanding Minds Psychological Services and/or the administrative and clinical staff at:

11144 Tesson Ferry Rd., Suite 101, St. Louis, MO 63123
Phone: 314-729-1200 Fax: 314-729-1201 Email: Clients@UnderstandingMindsStl.com

To release and obtain information from:

_____
Name of Person(s) or Organization(s) and Their Relationship to You

_____
Contact Information

Please check type(s) of information to be released:

____ Complete health record ____ Discharge summary ____ Diagnosis and treatment codes

____ Attendance and progress ____ Complete billing records ____ Other: Psychological evaluation

____ Other_____

Purpose(s) of Request:

____ Treatment or consultation ____ At request of the client/legal guardian ____ Billing or claims payment

____ Psychological evaluation ____ Coordination of care

____ Other_____

This authorization will remain in effect until _____ (date) or until 6 months after your last appointment.

By signing below I understand that:

I am allowing the release of my medical/health information. The protected health information (PHI) in my medical records includes mental health and behavioral health information. In addition, it may include information pertaining to sexually transmitted diseases, AIDS, HIV, other communicable diseases, and/or alcohol/drug abuse.

Alcohol and drug abuse information records are protected by federal regulations and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information.

Signature:_____

(flip over)

This Authorization includes both information presently compiled and information to be compiled during the course of treatment at Understanding Minds Psychological Services or agency paying for services during the specified time frame.

I have the right to revoke this Authorization at any time. I understand that to revoke this Authorization, I must do so in writing and present my written revocation to Understanding Minds. I understand that actions already taken based on this Authorization, prior to revocation, will not be affected.

I have a right to receive a copy of this Authorization.

A photocopy of this Authorization is as valid as the original.

Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected by federal or state law.

The following applies to alcohol/drug abuse treatment information records: Prohibition of Re-disclosure:
This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is not sufficient for this purpose.

Signature of client requesting disclosure:
Your provider will not deny treatment if you do not sign this form. By signing below, you authorize your provider at Understanding Minds, to release and/or obtain your protected health information to those specified above.

Signature of Client: _____

Date:_____

Signature of Legal Guardian/Parent/Representative:_____

Date:_____

Witness: _____

Date:_____