

The Pisgah Institute for Psychotherapy & Education, P.A.

158 Zillicoa Street, Asheville, NC 28801

(828) 254-9494. Fax (828) 254-0161 or (828) 250-0890

Mental Health Authorization for Disclosure of Protected Health Information (PHI)

Patient Name: _____ Date of Birth: ____/____/____

I understand that The Pisgah Institute is NOT required to obtain authorization to share my Protected Health Information for most purposes related to treatment, payment, or health-care operations. (See your copy of our Notice of Privacy Practices.) I understand that I have the right NOT to authorize release of my Protected Health Information for purposes other than treatment, payment, or health care operations. I understand that if Protected Health Information disclosed pursuant to this authorization is redisclosed by the recipient, it may no longer be protected by the HIPAA Privacy Rule. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol or other substance abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information unless I refuse permission to release information about HIV/AIDS or substance abuse. I also understand that if I refuse to sign this authorization for purposes other than treatment, payment, or health-care operations, my refusal to sign will not affect my ability to obtain treatment or information about my eligibility for benefits from any health-care provider or health plan named herein. However, if a service is requested by non-treatment provider (e.g., an insurance company) for the sole purpose of creating health information (e.g., about my eligibility for insurance coverage), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given. Release of my Protected Health Information may be significantly delayed if I specifically deny authorization to release information on HIV/AIDS or substance abuse because of the need to eliminate such information from my medical record before releasing it to the requestor.

I authorize (Provider's Name) _____

To send Protected Health Information to: _____
(Myself or name of healthcare provider, insurance company, attorney, or other recipient)

Recipient's Phone _____ Send to Fax _____

Send to Address _____
Street/P.O.Box _____ City _____ State _____ Zip Code _____

For the purpose of (Check):

- Coordination of care
- Legal/court matter
- Personal use
- Other purpose (specify) _____

I authorize the following PHI to be disclosed (Check):

If you select complete record, you must also select below:

- Transmission of Complete record
 - Transmission of Intake/discharge only
 - Transmission of Progress notes only
 - Transmission of Consult report only
 - Verbal Communication only (includes in-person, telephone, and/or electronic communication)
 - Other Protected Health Information (specify) _____
- HIV- and/or AIDS-related information
 - Substance-use information

This authorization may be relied upon when transmitted by fax or email (Check):

Yes No

I further authorize the Protected Health Information to be sent by fax (Check):

Yes No

I agree to hold The Pisgah Institute harmless if any Protected Health Information transmitted by fax or email does not reach the authorized recipient (Check):

Yes No

I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon, and this authorization shall remain in force for one year or until (Date): _____, 20____

I understand that a request for medical records may take up to 30 days for processing.

Signature of Patient, Parent (for minor or child), Legal Guardian, or Authorized Representative _____ Date _____

Signature of Witness (Required) _____ Date _____