PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize Willow Tree Mental Health Center, LLC to ☐disclose certain protected health information about the patient named below to and/or ☐receive protected health information about the patient named below from:

Name: _____ Address: _____

Phone: (____) _____ Fax: (____) _____ _____

Willow Tree Mental Health Center, LLC is hereby authorized to disclose the following protected health information (specifically describe the information to be disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

☐ All Medical Records ☐ Medication History ☐ Specific Information Listed Below:

_____

_____

_____

I understand that this request does not apply to: (1) certain health information that is not held in Willow Tree Mental Health Center, LLC's medical records; (2) psychotherapy notes (i.e., notes documenting or analyzing the contents of a conversation during a counseling session that are maintained separate from the rest of my medical record); (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA.

The information may be disclosed for the following purpose(s):

_____

_____

This authorization will expire one (1) year after the date of its execution or on_____ (name specific date or event), unless expressly revoked by me at an earlier time.

I understand that Willow Tree Mental Health Center, LLC may not condition my treatment on whether I sign this authorization.

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that I may revoke this authorization at any time by delivering a revocation in writing to Willow Tree Mental Health Center, LLC, and if I revoke this authorization, it will have no effect on actions already taken by Willow Tree Mental Health Center, LLC in reliance on this authorization.

I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient's personal representative.

Printed Name of Patient:_____ Date: _____

DOB: _____ Phone: _____

Signature of Patient or Patient's Personal Representative: _____

Printed Name of Personal Representative (if applicable): _____

Description of Personal Representative's authority (if applicable): _____

PATIENT/PERSONAL REPRESENTATIVE TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION UPON REQUEST