Commonwealth Therapy
COMMONWEALTHTHERAPY.COM – 617.383.7220

General Authorization to Disclose Protected Health Information

Patient Name______________________**Date of Birth** _____/_____/_____ **Phone number**____________________

I ____________________________________ (name of individual) authorize:

☐ Disclosure of the above named individual's Protected Health Information **by Leah K Barison, LMHC to the following organization(s) or person(s):** ____
____

☐ Disclosure of the above named individual's Protected Health Information **by the following organization(s) or person(s) to Leah K Barison, LMHC**: ____
____

☐ for client's personal records
☐ sharing between health care providers
☐ other (please describe): ____

I authorize use or disclosure of the following information: (check where applicable):

☐ entire record
☐ immunization records
☐ most recent encounter note
☐ medication list
☐ list of allergies
☐ most recent history/physical
☐ lab results (list types and dates):
☐ x-ray and imaging reports (list types and dates): ____
☐ consultation reports from (please supply doctors' names): ____
☐ other (please describe): ____

I understand that:

1. I may inspect or receive a copy of the Protected Health Information described by this Authorization upon payment of a reasonable fee.
2. This Authorization is voluntary and that I have the right to refuse to sign it.
3. I may revoke this Authorization at any time by providing a written notice of revocation as specified by the Notice of Privacy Practice; however such revocation would not affect any action taken by Leah K Barison, LMHC in reliance on this Authorization before receipt of my written revocation.
4. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on whether I provide Authorization for any requested use or disclosure by Student Health Services unless (a) the treatment is research related, (b) the information is needed for health plan eligibility or underwriting determinations, or (c) the sole purpose of creating the information is to disclose it to a third party.
5. This Authorization will expire on: ______________________or within 6 months whichever occurs first.
6. The information used or disclosed pursuant to this Authorization, except information protected by federal regulations about confidentiality of drug and alcohol abuse records, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.

I understand that my health record may include and I authorize disclosure of (check all that are applicable):
☐ Information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken.
☐ Genetic testing information including test results.
☐ Information about Sexually transmitted diseases
☐ Mental health counseling and behavioral health notes
☐ Information protected by 42 CFR Part II, federal laws protecting alcohol and drug abuse records.

______________________________________ ______________________
Signature of Individual Date

______________________________________ ______________________
Signature of Witness Date