Good Heart Therapy Services, PLLC
235 High Street Suite 311
Morgantown, WV 26505

www.goodhearttherapy.com
(304) 282-9750

Authorization for Use/Disclosure of Protected Health Information

Client Information

Client Last Name_____ First Name _____MI ___ DOB:___/___/____

Client Address _____

Client Address _____

Client Phone: _____ Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below.
Name of person/facility to receive medical information: _____

Phone: _____ Address:_____

Date of Authorization: ___/___/_____ Authorization expires on ___/___/_____ or when requested in writing.
Information to be Released (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.*)
□ My entire mental health record
□ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)
□ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)
□ Other: _____

Purpose of Information Release:
□ Further mental health care
□ Applying for insurance
□ At the request of the individual
□ Payment of insurance claim □ Legal investigation □ Vocational rehab, evaluation □ Disability determination
□ Other (specify): _____

Authorization and Signature
I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____/_____ Signature /Date

If signed by a personal representative:

(a) Print your name: _____
(b) Indicate your relationship to the client and/or reason and legal authority for signing:
Patient is: □ minor □ incompetent □ disabled □ deceased Legal authority: □ parent □ legal guardian □ representative of deceased