AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME _____Date of Birth _____
Address: _____
Phone _____
I authorize CAF Therapeutic Strategies LLC to: ☐ release to ☐ receive from
Name: _____
Address:_____
FAX _____ Phone _____
Email_____

Information to be released: ☐ psychiatric records ☐ psychotherapy records ☐ labwork. ☐ radiology ☐ dates of treatment ☐ treatment summary ☐ diagnosis ☐ psychological testing. ☐ medical records ☐ other (please specify) _____

Dates of Treatment to be shared: _____
Purpose of Disclosure: _____

1. I understand that, unless withdrawn, this authorization will expire 365 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying CAF Therapeutic Strategies at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
5. My healthcare and payment for my healthcare at CAF Therapeutic Strategies will not be affected if I do not sign this form.
6. I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ OR _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____
Relationship to Patient