Charm City Mental Health Practice, LLC
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Authorization For Use or Disclosure of Protected Health Information

Client Name: _____ DOB: _____

Who
I hereby authorize *Rachel Matyja, MS, LCPC of Charm City Mental Health Practice, LLC* to take the following action:

Action Requested

_____ Provide me with a copy of My Health Information
_____ Let me look at My Health Information (I am not requesting a copy)
_____ *Release My Health Information to: _____ *Discuss My Health Information with:
_____ *Obtain copies of My Health Information from:
*Name of other person or entity: _____
*Address: _____
*Phone number: _____ *Fax number: _____

What
For this authorization, "My Health Information" means (mark one or more):

_____ Academic Records
_____ Classroom Observation
_____ Drug & Alcohol Treatment Record
_____ Emergency Room Record
_____ Psychiatric Admission Note
_____ Psychological Evaluation/Testing
_____ Treatment Plan
_____ Admission History & Physical Exam
_____ Discharge Summary
_____ Educational Testing
_____ Progress Notes
_____ Psychiatric Evaluation/Diagnoses
_____ Psychosocial Assessment
_____ Other: _____

Purpose of Disclosure

_____ At my request
_____ Academic coordination
_____ For payment/insurance purposes
_____ For my healthcare/treatment/coordination of care
_____ For legal purposes
_____ Other: _____

Authorization and Signature
I authorize the release of my confidential protected health information, as described above. I understand that this authorization is voluntary. This authorization is valid for one year from the date signed below, unless an earlier date is specified here: _____. A photocopy of this form shall be as valid as the original. I may cancel this authorization in writing at any time. I understand that cancellation of this authorization does not apply to information received or disclosed prior to receipt of my written request to cancel this authorization. Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, unless the recipient is covered by laws that limit the use and/or disclosure of my protected health information.

Signature of Client: _____ Date: _____

Signature of Personal Representative: _____ Date: _____

Relationship to Client, if Personal Representative:

_____ Parent with Parental Rights
_____ Legally Appointed Healthcare Agent
_____ P.O.A. with Right to See Medical Records
_____ Registered Kinship Care Relative
_____ Medical Power of Attorney
_____ Court Appointed Personal Representative of Deceased
_____ Court Appointed Guardian
_____ Surrogate Decision Maker