MALE BEHAVIORAL HEALTH

Authorization to Use and Disclose Protected Health Information

I, _____, hereby authorize MALE BEHAVIORAL HEALTH to use, obtain, and share mental health treatment information and records obtained in the course of psychotherapy treatment for me or for my minor child _____ from/ with:

(name of child under 18 years old)

Name of other provider: _____

Address: _____

Phone Number: _____ Email Address: _____

I understand that I have the right to receive a copy of this authorization. I understand that I have the right to revoke this authorization at any time, that such revocation must be in writing, and received by MALE BEHAVIORAL HEALTH, to be effective. This will prevent further releases after this time but cannot change the fact the some information may have been sent or released before that date. Also, you may have the right to inspect and receive a copy of the health information described in this authorization.

The disclosure of information and records is required for the following purposes:

_____

_____

_____

The information used or disclosed in this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy rule, although applicable Ohio law may protect such information.

This authorization shall remain valid until _____

Signature of Client (if over 18):_____ Date:_____

Printed Name:_____

Signature of Parent/Guardian:_____ Date:_____

Printed Name:_____

Model form prepared by Barry Mintzer, Esq,

NASW Lawyer

ADDRESS
457 Waterbury Ct, Suite G,
Gahanna, OH 432305

CONTACT
T: (614) 360-9702
E: info@mbhinc.com
W: www.mbhinc.com