Steven S. Schwartz, Ph.D. & Associates

Julie M. Canfield, Psy.D.

Clinical Psychologist

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

(This authorization must be written, dated, and signed by the client or by a person authorized by law to give authorization)

I authorize _____ to: ____ obtain protected information from, OR ____ disclose protected information to:

Name: _____ Phone: _____ Address: _____

Regarding: _____ For the following purpose(s): ___ Treatment planning ___ Referral
Client name DOB ___ Coordination/continuity of care
___ Other: _____

Consisting of the following information: _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

Provider Information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You make revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to Julie M. Canfield, Psy.D. at 7650 Rivers Edge Dr. Ste. 140 Columbus, OH 43235 and state that you are revoking this authorization.

Signature

I have read this authorization and I understand it. Unless revoked, this authorization expires at the following time:

_____(specified date or event).

_____ _____
Client Date

- OR -

_____ _____
Client's Representative Date

Description of representative's authority: _____

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