5525 Erindale Dr, 217C, CO Springs, CO 80918
Tel: 719-413-6930 Fax: 719-247-3940

Embrace Psychological Services

Website: www.embraceps.com
E-mail: contact@embraceps.com

Authorization to Release Protected Health Information (PHI)

Child/Adolescent

Your Protected Health Information (PHI) includes any individually identifiable health information (e.g., medical records) that is transmitted or maintained in any form (e.g., orally, electronically, by mail).

Today's Date: _____/_____/_____
mm dd yyyy

Client Information

Client Name	_____	DOB	_____/_____/_____ mm dd yyyy

Parent/Legal Guardian Information

Name	_____	Relationship	_____
Email address	_____	Phone	_____

Agency and Release Information

What are you authorizing (check all that apply)?

☐ I do hereby consent to authorize Embrace Psychological Services to disclose client PHI to a person or agency.
☐ I do hereby consent to authorize a person or agency to disclose client PHI to Embrace Psychological Services.

Who is the other person or agency you are authorizing (as applicable)?

Name	_____
Phone Number	_____-_____-_____
Email Address	_____
Mailing Address	_____

Transmission Modes - how may records be released (check all that apply)?

☐ Electronic (Secure Email, Fax, Upload) ☐ Verbal ☐ Written

What specific PHI are you authorizing to be disclosed to the other party?

☐ Assessments/Evaluations
☐ Psychological Tests/Reports
☐ Educational/Developmental Records
☐ Psychotherapy Session/Progress Notes
☐ Treatment Plans
☐ Service Recommendations
☐ Discharge/Transfer Recommendations
☐ Teacher/Observer Assessments for Completion
☐ Scheduling
☐ Billing
☐ Other: _____

What is the purpose of the release?

☐ Comprehensive care coordination
☐ Determine eligibility for services
☐ Personal Use
☐ Other: _____

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Additional Information

Please note: the records released may contain alcohol and drug abuse information and/or information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC)

Alcohol/Drug Abuse:

☐ I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.
☐ I PROHIBIT the release of information relating to referral and/or treatment for alcohol and drug abuse.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease:

☐ I authorize the release of information relating to HIV/AIDS/Sexually Transmitted Disease/Communicable Disease.
☐ I PROHIBIT the release of information relating to HIV/AIDS/Sexually Transmitted Disease/Communicable Disease.

Between which dates of service are you authorizing the disclosure of your PHI?

This part must capture the intended dates of service for this form to comply with HIPAA regulations. You may estimate if you are unsure of the month/day.

Start of service date _____/_____/_____ (mm dd yyyy)

End of service date _____/_____/_____ (mm dd yyyy)

If you intend this authorization to capture any future dates of service, choose one year from now in the "End of service date" box. If you are authorizing an exchange of all information (e.g., we may send records to the provider/agency and they may send records to us), be sure to identify the date you began seeing whichever provider/agency you have been seeing the longest. If you are authorizing disclosure to a non-provider (e.g., a teacher, parent, spouse, etc.), choose the dates of services at Embrace Psychological Services you intend to authorize. You may estimate if you are unsure, but the dates must capture the date(s) of service you are authorizing.

I understand that:

Information disclosed based on this Authorization, except for information about a substance use disorder, may be re-disclosed by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) (45 CFR part 164). Records about a substance use disorder will continue to be protected under federal rules following disclosed and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the relevant rules (42 CFR part 2). I cannot be required to sign this Authorization as a condition for treatment, payment, enrollment, or eligibility for benefits. EPS may not refuse to treat me if I refuse this Authorization unless the purpose of the treatment is to provide information to the individual/entity identified in this Authorization. Substance Use Disorder-related information can be released in the event of a bonafide medical emergency without consent. Under 42 CFR Part 2, I have the right to request a list of disclosures to which disclosures have been made pursuant to the general designation – For 42 CFR Part 2 violations, I can contact the US Attorney for Colorado at 1801 California Street, Suite 1600, Denver, CO 80202, 1-303-454-0100. EPS has no control over this information after it is released and is not liable for any other disclosures. I may revoke (cancel) this Authorization at any time by notifying EPS in writing or by signing the revocation form. If not revoked, this Authorization will expire two (2) years from the date I sign it unless a date is specified below. My signature below means I understand and accept the terms of this Authorization. A copy of this Authorization (including fax) is as valid as the original. I have a right to receive a copy of the signed Authorization.

Client Name	_____	
If 12 or older - Client Signature	_____	
Parent/Legal Guardian Name	_____	Relationship: _____
Parent/Legal Guardian Signature		
Effective Date	_____/_____/_____ (mm dd yyyy)	
Expiration Date	_____/_____/_____ (mm dd yyyy)	

☐ Client/Parent/Legal Guardian/unable to sign (identify reason): _____