Authorization for Use or Disclosure of Protected Health Information (Release of Information)

COMPLETE ALL SECTIONS, DATE AND SIGN

I, _____ Birthdate _____SSN _____

authorize Independence Center, 4245 Forest Park Ave. St. Louis, MO 63108 to

☐ **Release** to ☐ **Obtain** from the information selected below:

Name of person/organization/facility	
Address	
City, State, Zip	
Secure email/Fax number	

Approved Methods of Disclosure: ☐Oral ☐Written ☐Electronic

Purpose or need for this release is:

☐Continuity of Care ☐Legal ☐School ☐Research ☐Family/Natural Support Participation

☐Information Sharing ☐Insurance ☐Disability ☐Other_____

Information to be disclosed or obtained:

☐Clinical Assessment/Bio-Psycho-Social ☐Treatment Plan ☐Psychiatry Notes

☐Mental Health Progress Notes ☐Medication List ☐Discharge Summary

☐Alcohol/Substance Use Treatment Notes ☐History & Physical ☐Progress/Wellbeing/Status

☐Other _____

Dates of Service: From _____ To_____

I understand that neither Independence Center nor any affiliated healthcare providers can require me to sign this form as a condition of receiving treatment, making payments, or gaining enrollment or eligibility in any insurance plan, unless federal privacy regulations allow it.

I understand that the information disclosed may be subject to redisclosure by the person or entity receiving it and would no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying PrivacyOfficer@independencecenter.org in writing of my desire to revoke it. I understand that any actions already taken based on this authorization cannot be reversed and my revocation will not affect those actions.

This authorization expires on _____.

If no date is specified, the authorization automatically expires one year from the signature date.

_____ _____

Signature Date

_____ _____

Signature of Legal Guardian/Representative Date

_____ _____

Witness Date