growtherapy
Email: billing+records@growtherapy.com

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (MENTAL/BEHAVIORAL MEDICAL RECORDS)

Completion of this document authorizes the disclosure and/or use of mental health information about you. Failure to provide all information requested may invalidate this authorization.

PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____

Email: _____ Phone: _____

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The party below may disclose health information:

Grow Therapy (*Optional - Specify provider:* _____)

Information may be disclosed to the following recipient:

Name of Person/Entity: _____

Phone: _____ Fax/Email: _____

_____

Street Address City State Zip Code

I authorize disclosure of the health information described below (<u>check all that apply</u>):

Date(s) of Service / Date Range: _____

☐ All records regarding my mental/behavioral health treatment

OR

☐ Progress notes
☐ Billing records
☐ Treatment Summary
☐ Discharge Summary
☐ Psychiatric evaluation
☐ Medications
☐ Other: _____

The purpose of this use or disclosure (<u>check one</u>):

☐ Patient request ☐ Continuity of care

☐ Insurance ☐ Other (*<u>please specify</u>*):

☐ Legal _____

Expiration: This authorization shall be effective immediately and will expire one (1) year from the date signed unless another date is specified below:

Optional - Alternate expiration date: _____/_____/_____

RIGHTS & ACKNOWLEDGEMENTS

I understand I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I understand that I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: billing+records@growtherapy.com. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I understand that information used or disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by state or federal confidentiality law (HIPAA).

SIGNATURE

Signature: _____ Date: _____/_____/_____

If signed by someone other than the patient, please provide your printed name and indicate your legal relationship to the patient:

Printed Name: _____

Relationship to patient:

☐ Guardian ☐ Healthcare Power of Attorney (POA) *

☐ Other legally authorized representative * (*<u>specify</u>*): _____

** Document(s) demonstrating legal authority (ex: healthcare POA) must be provided along with this form to avoid processing delays.*