TERRAP ANXIETY AND PHOBIA CARE
COGNITIVE AND BEHAVORIAL HEALTH ASSOCIATES

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AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by the above-named practice

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s): _____

☐ Other: _____

You may disclose this health information to:

Name (or title) and organization_____

Address: _____City _____State _____Zip_____

Information to be disclosed (check all that apply)

☐ Medical Records ☐ Treatment Records ☐ Diagnostic Records

☐ Other: _____

Reason(s) for this authorization (check all that apply):

☐ at my request
☐ other (specify)_____
_____

This authorization ends: ☐ on (date) _____
☐ when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study.

  or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office.

  or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative, etc.)