Authorization to Release/Exchange Protected Health Information (PHI)

Purpose: Coordination/continuity of care for ____
(Client Name)

Party to Receive/Release PHI:

____
(Name) (Phone/Fax) (Address)

May we communicate via email with the above party? ☐ Yes ☐ No

If you wish to RESTRICT the exchange of information, please select which of the following you authorize to be released/exchanged:

☐ Aftercare Plan
☐ Diagnosis
☐ Treatment Plan
☐ Dates of Treatment
☐ Progress to Date
☐ Summary of Treatment
☐ Other:

I hereby authorize staff clinicians at Foundry Clinical Group to release/exchange my PHI both within Foundry Clinical Group and to the specific party designated above.

Applicable rules of confidentiality will be observed regarding information that is received and exchanged under this agreement. Foundry Clinical Group will release your PHI only with careful clinical consideration.

I understand that:

- This authorization is voluntary.
- This exchange and/or receipt of information is intended solely for the purpose of furthering treatment.
- Treatment will not be affected if I do not sign this form.
- This authorization is effective immediately.
- I may revoke this authorization at any time by written notification. If I do revoke this authorization, it will not affect any actions taken before the revocation is received.
- Information disclosed as a result of this authorization may no longer be protected by federal privacy laws, and may be disclosed by the company or individual receiving the information.
- A photocopy/reproduction of this authorization shall be considered as effective and valid as the original.
- I have a right to receive a copy of this document.

Signature ________________________________ Date ____________________

Printed Name ________________________________

Foundry Clinical Group
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