



## 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:

- |   |   |                                 |
|---|---|---------------------------------|
| <input type="checkbox"/> Aftercare Plan | <input type="checkbox"/> Dates of Treatment   | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Diagnosis      | <input type="checkbox"/> Progress to Date     |                                 |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Summary of Treatment |                                 |

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 and expires 120 days after the express termination of treatment.
- 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 \_\_\_\_\_