Behavioral Health HIPAA Authorization

Patient Name

Date of Birth

Address

Phone Number

Name of Provider or Entity Authorized to Disclose Information

Name of Person or Entity Authorized to Receive Information

Specific Information to be Disclosed

Purpose of Disclosure

Expiration Date or Event

Additional Restrictions or Comments

I understand that:

- This authorization is voluntary and treatment is not conditioned on my authorization.
- I may revoke this authorization at any time in writing.
- Information disclosed pursuant to this authorization may be subject to redisclosure.

Signature of Patient/Representative

Date