Catholic Charities Bloomington (CCB)
Authorization for PHI Use/Disclosure

Client Name: _____ Date of Birth: _____ Case Record No.: _____

Client Address: _____

By signing below, I hereby authorize the use or disclosure of the above-named Client's individually identifiable and protected health information ("PHI") by the above named Practice for the specific purpose(s) stated below [which do not relate to the day-to-day functions performed with regard to my Treatment, Payment and certain Health Care Operations and are not otherwise required or permitted by law].

Authorization is given to:

[ ] Release information from CCB [ ] Release information to CCB [ ] Release and request information to and from CCB

Person/Entity to Release to or Exchange with: Person/Entity: _____

Address: _____

City/State/Zip: _____

Instructions: Patient to "X," Date, and Initial All Applicable Sections Before Signing.

1. The Type and amount of my PHI to be used or disclosed by the Practice is as follows, subject to any content or time limits listed below:
   ___ Entire Client Record (or specify below)
   ___ Medical History ___ Treating/Consulting Physician Reports ___ Most Recent Discharge Summary
   ___ Treatment Plan ___ Psychosocial Assessment ___ Educational Records
   ___ Billing Information ___ Other _____

2. State the particular purpose(s) and any client-imposed limitation(s) or expiration date, event or condition(s) or "none" here:
   _____

3. If my PHI contains information regarding a communicable disease, [including but not limited to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), mental health psychotherapy services, treatment for alcohol or other drug abuse, or genetic testing information ("Special PHI"), then I hereby authorize the following Special PHI to be disclosed to the above-named Person/Entity for the following purpose(s):

(Please Specify)	**Purpose of Disclosure to Person/Entity**
___ Communicable Disease(s)	_____
___ Mental Health Services	_____
___ Alcohol or other Drug Treatment	_____
___ Genetic Testing Information	_____

4. I understand that if I do not specify an expiration date, event or condition in (2) above, this Authorization will expire in sixty (60) days (or in the case of PHI concerning mental health services, one hundred and eighty (180) days) from the date this Authorization is signed by the above-listed **or otherwise noted below:**
   ___ Authorization is valid as long as I am in treatment with CCB
   ___ Other expiration date (Date this release will expire): _____ **____ (Initials)**

5. I understand that the PHI used or disclosed may be subject to redisclosure by the Person/Entity receiving it and no longer protected. **____ (Initials)**
6. I understand that my signature on this Authorization is voluntary and my refusal to sign will not affect my ability to receive treatment from the Practice. I understand that I have a right to revoke this Authorization at any time, in a letter addressed to CCB at the above-listed address, but the revocation will not apply (1) to PHI that has already been released in reliance on this Authorization, or (2) to PHI created by CCB expressly for disclosure to the above-listed Person/Entity. **____ (Initials)**
7. I understand that if I have any questions regarding the use/disclosure of my PHI, I can contact CCB at any time. **___(Initials)**

Signature of Client or Client's representative: _____ Date: _____

Print name of client representative: _____ Relationship to client: _____

Witness: _____ Date: _____