HIPAA Authorization to Release Protected Health Information Form
ASU Clinical Psychology Center

1. **Authorization**
   I, _____, give my permission for ASU Clinical Psychology Center (healthcare provider) to share the protected health information described below to _____ (organization receiving the information).

2. **Health Information**
   I authorize the release of:

   ☐ My complete health record (including records relating to mental health assessment and treatment, diagnoses, communicable diseases including HIV or AIDS, and treatment of alcohol or drug abuse).

   OR

   ☐ My complete health record except for the following information:
   - ☐ Mental health records
   - ☐ Communicable diseases (including HIV and AIDS)
   - ☐ Alcohol and drug abuse treatment
   - ☐ Other (please specify): _____

   OR

   ☐ Only the following information: _____
   _____

3. **Reason for Disclosure**
   This protected health information is being released for the following purposes:
   _____
   _____

4. **Duration of Authorization**
   This authorization to share protected health information is valid:

   ☐ From _____ to _____

   OR

   ☐ From the date of the signature until the following event: _____
   _____

5. Rights

- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

6. Signatures

_____ _____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative and his or her relationship to patient

_____ _____

Signature of witness Date

7. Documentation of Information Released

Information Released	Date	Staff Initials