A Village for One

Uniting our community to uplift, support, heal, and build a home
for youth impacted by commerical sexual exploitation and trafficking.
www.avillageforone.org

Authorization to Obtain, Use and Disclose Protected Health Information

Client Name: _____ **DOB:** ____/____/____

With my signature below, I authorize A Village for One to OBTAIN information from and RELEASE information to:

Contact Person: _____ **Organization:** _____

Address: _____ **Telephone #:** _____

City, State, Zip: _____ **Fax:** _____

Information to be obtained/used/disclosed consists of mental health information, including:

__ Assessment or Evaluation __ Treatment Plan __ Coordination of Care Information

__ Notes __ Other: _____

The purpose for the disclosure/communication:

__ Coordination of Care __ Other: _____

I understand that additional laws about mental health, HIV/AIDS, genetic, and alcohol/drug treatment information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space.

Initial: ____ Mental Health Information **Initial:** ____ Genetic Testing Information

Initial: ____ Drug/Alcohol Diagnosis, Treatment or Referral Information

Initial: ____ HIV/AIDS Information

Other Information

I understand that I am not required to sign this authorization. If I refuse to sign this, it will not prevent me from getting mental health or drug/alcohol treatment at A Village for One. The only exception is if the services I am seeking are only for providing health information to someone else and this authorization is needed to make the disclosure.

I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed for the reasons described here. If A Village for One has already used or disclosed information, that cannot be undone. To revoke this authorization, I can request the form from A Village for One front office or my provider and return the completed form to my provider or the front desk.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS; mental health information; genetic testing information; and drug/alcohol diagnosis, treatment, or referral information.

Unless revoked, this authorization expires 60 days after completion of treatment or: _____

I have read this authorization and understand it.

Client Signature: _____ Date: _____

Parent/Guardian/Representative Signature: _____

If representative print name: _____

Relationship to client:

__ Parent __ Legal Guardian __ Power of Attorney/Healthcare

__Other: _____