Genesis Behavioral Health

# Authorization Form for Release of Protected Health Information

Patient Name:_____ Date of Birth:_____

I grant permission for my healthcare provider and their representatives of Genesis Behavioral Health to discuss my care using this disclosure form to share relevant information about my healthcare or discuss financial information for payment on my account.

**Release my protected health information to the following person(s)/entity:**

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

The information you may release subject to this authorization is the following:

Appointment date/time ☐Yes ☐No Explanation of diagnosis and/treatment plan ☐Yes ☐No

Lab Reports ☐Yes ☐No Billing Information ☐Yes ☐No

☐ **I do not want any of my information shared with family or friends.**

I consent to Genesis Behavioral Health to leave a message on my voicemail regarding my lab care:
☐Yes ☐No

I understand that my healthcare information at Genesis Behavioral Health is protected. By signing this form, you are granting Genesis Behavioral Health to disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this information. The terms of our Notice may change, and if so, you may obtain a revised copy by contacting our office. If you would like a copy of our Notice of Privacy Practices, please see the front desk.

_____

Patient/Authorized Representative Signature Date

*This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Genesis Behavioral Health.*

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