AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

<u>Authorization for Use/Disclosure of Information</u>: I (name of client or legal guardian of minor) _________________________ Client DOB_________ voluntarily consent to and authorize my provider and SAFE SPACE FOR FAMILY HEALING, LLC to use or release health information for (name of client)__________________________during the term of this Authorization to the recipient(s) that I have identified below.

<u>Recipient</u>: I authorize my health care information to be released to the following recipient(s):

Name:____

Address:____

<u>Purpose</u>: I authorize the release of my health information for the following specific purpose (circle all that apply):
At My Request
Continued Medical or Mental Health Care
Other: ____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

<u>Information to be disclosed</u>: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my mental health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me/ the client.

- ❑ Only the following records or types of health information: ____.

<u>Term</u>: I understand that this Authorization will remain in effect:
- ❑ From the date of this Authorization until the _____ day of ________, 20___.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:____

Redisclosure: I understand that SAFE SPACE FOR FAMILY HEALING, LLC cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at SAFE SPACE FOR FAMILY HEALING, LLC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the SAFE SPACE FOR FAMILY HEALING, LLC. The revocation will be effective immediately upon my provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may request a copy of this form and I may contact the SAFE SPACE FOR FAMILY HEALING, LLC for answers to my questions about the privacy of my health information at (301) 841-5352.

____________________________	__________________	___________________
Signature	Date	Signature of Witness

If Individual Client is unable to sign this Authorization, please complete the information below:

______________________	________________	________	_____________________
Name of Guardian/ Representative	Legal Relationship	Date	Signature of Witness