

CHILDREN'S RESOURCE GROUP / CRG ASSOCIATES
Authorization for Disclosure of PHI

I, _____, the undersigned, hereby authorize Children's Resource Group / CRG Associates to use or disclose protected health information of the Patient identified below in the manner described in this authorization:

Patient's Name: _____ **Patient's Date of Birth:** _____

Children's Resource Group / CRG Associates has permission to:

****Mark with an "X" and complete lines below.** Release PHI _____ Obtain PHI _____ Exchange PHI _____

If to a person:

| | |
|------------------------------------|--|
| _____ | _____ |
| Last Name, First Name | Association or relationship to Patient |
| _____ | _____ |
| Address (Street, City, State, Zip) | Telephone and/or Fax |

If to an entity:

| | |
|-------------------|------------------------------------|
| _____ | _____ |
| Legal Name | Address (Street, City, State, Zip) |
| _____ | _____ |
| Contact Person(s) | Telephone and/or Fax |

The PHI to be disclosed is as follows:

****Mark and "X" on all applicable sections before signing.**

_____ Psychological Evaluation _____ Psychiatric Evaluation _____ All Progress Notes/Appointment Records
_____ Treatment Summary _____ Medication History _____ Lab Results
_____ Email correspondence _____ Other (Please specify): _____

****State the specific purpose for the disclosure below:**

****Please indicate:**

_____ This is a request to mail/fax records and requires immediate attention _____ Please keep on file for an as needed basis

I, the undersigned, have read or been informed of the following:

- (1) 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.
- (2) I understand that I have a right to revoke this Authorization at any time but any such revocation will not apply (1) to PHI that has already been released in reliance on this Authorization, or (2) to PHI created by the Practice expressly for disclosure to the above-listed Person/Entity.
- (3) I understand that this authorization will expire in one hundred eighty (180) days from the date the authorization is executed, unless revoked by me prior to that date.
- (4) I understand that the PHI disclosed may be subject to re-disclosure by the Person/Entity receiving it and no longer protected by the federal privacy regulations except in the case of drug and alcohol treatment records which must be clearly stamped "Do Not Re-Disclose" and protected accordingly under 42 CFR part 2.
- (5) I understand that if I have any questions regarding the use or disclosure of my PHI, I can contact Children's Resource Group at any time.

Printed Name of Patient / Legal Representative

Signature of Patient / Legal Representative

If Legal Representative, Please Indicate Relationship to Patient: _____

Witness

Date