Molina
Psychological Consultants

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Name of Patient:_____

I authorize my mental health clinician and/or administrative and clinical staff to (check all that apply):

_____ Disclose protected health information to:

_____Consult regarding protected health information with:

_____
(Specifically state whom will receive this information)

This protected health information is being used or disclosed for the following purpose:

_____
(Specifically state purpose of the information being released. "At the request of the individual" or "Coordination of Care".

This authorization shall be in force and effect until _____, or until the termination of my treatment at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Contact at 2102 Business Center Drive, Suite 130, Irvine, CA 92612. I understand that a revocation is not effective to the extent that my clinician has relied on the use or disclosure of the protected health information 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 information used or disclosed pursuant to this authorization may be disclosed by the recipient and may not longer be protected by federal or state law. My clinician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefit (if applicable) on whether I provide authorization for the requested use or disclosure. The use or disclosure requested under this authorization will result in direct or indirect remuneration to my clinician from a third party.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Signature of Parent or Legal Guardian Date