Mind's Eye
Center for Mental Health and Wellness

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Authorization to Use/ Disclose Protected Health Information

Please complete and sign this document if you wish to authorize Mind's Eye to use and/or disclose your "protected health information" (PHI), or your child's PHI, to the below named person or entity. Doing so is completely voluntary and is not a condition of receiving treatment at Mind's Eye. Mind's Eye is not liable for any use or disclosure of your PHI that may occur by third parties you authorize us to disclose it to. This authorization will expire in 180 days, unless you revoke it before then. To revoke this authorization, please send an email indicating your intentions to: cevans@mindseyemh.com.

Patient Name: **Patient DOB:**

I authorize Mind's Eye to: ☐**Disclose PHI to:** ☐**Use (obtain) PHI from:**
Name/Organization:

Phone:

Fax:

I authorize Mind's Eye to disclose this PHI by means of unencrypted email:
☐yes ☐no

Check the categories of PHI you authorize Mind's Eye to use (obtain) and/or disclose:
☐Evaluation, Studies & Diagnosis ☐HIV status

☐Treatment Records ☐School Records

The reason I'm authorizing this disclosure/ use:
☐Coordination of care ☐Other:

Signature of Patient (if over 14):_____

Printed Name: _____ Date:_____

Signature of Parent/ Guardian (if needed):_____

Printed Name: _____ Date:_____