Amour de Soi
Behavioral Health Services

Rachel G. Folger, PMHNP-BC
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AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____

Patient Name Date of Birth

I authorize Rachel G. Folger, PMHNP-BC, to use, disclose or obtain my/mychild's protected health information to/from:

Name:_____

Organization:_____

Address: _____

Street City/Town State Zip Code

The specific purpose of this use/disclosure is for coordinating care. The specific information to be used, disclosed, or obtained is as follows:

Mental Health Record.	Discharge Summary	History & Physical Exams
Psychiatric Evaluation	Medical Evaluation	Treatment Plan
Complete Record	Educational Records	Other: _____
Verbal Communication with another provider: _____		

Unless revoked, this authorization expires at the end of treatment. I understand that the best possible outcomes are achieved only through a collaborative approach to treatment. I acknowledge that I have signed this authorization voluntarily. I acknowledge that I have the right to revoke this authorization at any time by submitting my request in writing to Rachel G. Folger, PMHNP-BC. I understand that I cannot revoke the authorization of information that has been previously used, disclosed, obtained under this authorization.

_____ _____

Patient/Parent/Guardian Signature Date

_____

Print Name

_____

Relationship to Patient