Authorization for Disclosure, Use or Receipt
Of Protected Health Information

You have the right to refuse to sign this authorization. John Watterson, Ph.D. will not withhold treatment, insurance benefits or payment processing if you refuse to sign this authorization.

Patient Name: ___________________________________ DOB: ________________
I authorize John Watterson, Ph.D. to disclose/use/receive the following protected health information about me: _____ entire mental health record
_____ partial mental health record – specifically: ________________________________
_____ telephonic/ email consultation

John Watterson, Ph.D. may disclose to/receive from:
Name of Individual or Organization: ____
Address: ____
Phone: ______________________ Fax: ________________________

The disclosure / use is for the following purpose(s):
_____ to coordinate treatment planning
_____ to assist in a legal matter
_____ to discuss with my spouse/family the care and treatment I receive
_____ to inform my employer/school of my treatment and its implications
_____ at my request or other reason: ____
I also authorize the disclosure/use/receipt of my health information regarding:
_____ HIV / AIDS _____ alcohol and drug abuse treatment

Unless this authorization is revoked earlier it will expire on: ________________________
date, event, or condition of expiration

Note: For individuals receiving alcohol or drug abuse treatment, this form serves as the consent required by 42 CFR Part 2.31.
Note: If you are authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then medical privacy laws no longer protect it.
Note: If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of an adult, the information disclosed/used/received may contain references about you and your family.

You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to John Watterson, Ph.D., which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by Dr. Watterson, except to the extent that Dr. Watterson has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.

____ ____________________
Patient's signature Date

______________________________ ________________________ ______________
Representative's signature, if any Representative's relationship to patient Date