SUMMIT CENTER
Reach New Heights
Assessments • Consultation • Counseling

AUTHORIZATION TO USE/DISCLOSE HEALTH CARE INFORMATION

Completion of this document authorizes the disclosure of individually identifiable health information, as set forth below, consistent with California and Federal Law concerning the privacy of such information.

Client Name:_____Birth date: _____

Maiden or other name (if applicable): _____

I request and authorize Summit Center staff_____to release the health care information described below to:

Name:_____phone number: _____

Please initial to specifically authorize the use and/or disclosure of:

____ Emergency Room/Urgent Care Records

____ Hospital Records (nursing and progress notes)

____ Initial Psychological Evaluation

____ Medication History

____ Billing Statements

____ Consultation Report (specify):_____

____ Other (specify):_____

____Admission Note

____Discharge Summary

____Clinical Summary

____Psychological Test Report

____Verbal Discussion of Case

____Intake Forms (i.e Parent Questionnaire, etc)

The requested records or information is about health care provided during the following approximate time frame:

_____

Authorization expires: _____

I understand that I may rescind this consent at any time through written request stating that I do not give permission for further release or disclosure of information.

Date:_____ Client/Authorized Representative _____
(Signature)

Date:_____ Client/Authorized Representative _____
(Signature)