



**MENTAL HEALTH SERVICES
AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION**

I am completing this form to allow the use and sharing of Protected Health Information about:

Minor Child/Client's Name _____ Social Security # and/or DOB: _____

My Information:

Parent/Guardian Name: _____ Relationship: _____

Address: _____ Telephone: _____

I hereby authorize:

Agency: Morningstar Mental Health Services 220 Santo Domingo Drive, Brunswick, GA 31525

Phone: (912) 267-3701 Fax: (912) 267-0235

To: ☐ OBTAIN Protected Health Information (PHI) from: -and/or- ☐ RELEASE/DISCLOSE PHI to:

Name/Agency: _____

Address: _____

Phone: _____ Fax: _____

Specific Protected Health Information (PHI) covered in this Authorization: (Check all that apply)

- | | |
|--|--|
| ☐ Any Inpatient or outpatient treatment records for physical and/or psychiatric and/or drug and/or alcohol abuse | ☐ psychosocial histories |
| ☐ Admission and discharge summaries | ☐ Psychiatric evaluation(s), reports, assessments |
| ☐ Psychological evaluation(s), reports, assessments | ☐ Behavioral observations or checklists |
| ☐ Case Records/Reports | ☐ Aftercare plans |
| ☐ Treatment plans | |
| ☐ Educational records, including achievements, test results, behavior reports/other school, special education documents | |
| ☐ Medical history | ☐ Lab results, as specified _____ |
| ☐ Other: _____ | |

- **Expiration:** I understand and agree that this Authorization will be valid and in effect until _____ (enter a date or event not to exceed one year) unless I choose to revoke (cancel) it. I understand that after that date or event, no more of this information can be obtained by/released to the person or organization unless I sign a new Authorization like this one.
- **Revocation:** I understand that I can revoke or cancel this Authorization at any time by sending a letter to the Privacy Officer, Morningstar Children and Family Services Inc. at the address above. If I do this, it will prevent any releases after the date it is received but can not change the fact that some information was sent or shared before that date.
- I understand that I do not have to sign this authorization and that my refusal to sign will not be cause to prevent my minor child from obtaining services from Morningstar Children and Family Services Inc.
- I understand that I may inspect and have a copy of the health information described in this authorization.
- I understand that if the person/entity that receives the information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I affirm that everything in this form that was not clear to me has been explained and I believe I understand all of it.
- I acknowledge that I received a copy of this form if requested and all blanks were filled in.

Guardian Printed Name

Guardian Signature

Date

I have discussed the issues above with the client and/or his/her authorized representative. I believe that this person understands and was capable of giving informed and willing consent.

Morningstar Staff Printed Name

Morningstar Staff Signature

Date

REVOCATION

Date Consent Revoked: _____ Signature: _____

Privacy Officer or Designee