Authorization to Discuss Care

This form must be filled out if billing/appointments or care are to be discussed with anyone other than the client or their legal guardian. (for example other family members or caregivers)

I hereby authorize Alliance Mental Health to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

☐ Appointment Dates /Times

☐ Billing

☐ Diagnosis

☐ Other (specify)

☐ Care Plan

Information to be given to:

Name:	Relationship:	
Address:		
City:	State:	Zip:
Phone:	Please Indicate: Home /Work /Cell Work	

This authorization shall remain in effect from the date signed below until (please specify):

(specify expiration date or event) No Expiration Date

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting Alliance Mental Health.
- This authorization is giving Alliance Mental Health the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.

Patient Name:	Date of Birth:
Signature (Patient/Guardian):	Date:
Name of Guardian (if applicable):	