

FAMILY BASED THERAPY ASSOCIATES

GENERAL AUTHORIZATION FORM

NAME OF INDIVIDUAL: _____ DATE OF BIRTH: _____

I hereby authorize **Family Based Therapy Associates** to use, disclose, or exchange protected health information about me. The use or disclosure shall be limited to the information, persons, purposes, and timeframe described below:

INFORMATION TO BE USED OR DISCLOSED

I authorize the use or disclosure of the following protected health information created between ___/___/___ (mm/dd/yy) and ___/___/___ (mm/dd/yy) about me: (describe the information as specifically as possible)

- | | |
|--|--|
| <input type="checkbox"/> Official School Records (name, address, birth date, sex, attendance record, grade level, grades, class rank, standardized group test results) | <input type="checkbox"/> Chemical Abuse/Dependency Report |
| <input type="checkbox"/> Health Records | <input type="checkbox"/> Medical Report (including related services) |
| <input type="checkbox"/> Psychological Reports | <input type="checkbox"/> Social Work Report |
| <input type="checkbox"/> Special Education Records (including related services) | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Teacher, Counselor, Staff Observations | |

PERSON TO USE OR RECEIVE THE INFORMATION

I authorize the following person(s) to use or receive the disclosure or the exchange of my protected health information (Name/Title/Organization):

PURPOSE OF THE REQUESTED USE OR DISCLOSURE

The protected health information may be used for each of the following purposes:

- At the request of the individual
- Coordination of county case management with counseling services
- Other (specify) _____

EXPIRATION DATE

authorization will automatically expire:

- ___/___/___ (mm/dd/yy) (May not exceed 12 months from the date of the signature on this form); OR
- When the following event occurs _____

PLEASE NOTE THE FOLLOWING:

You may refuse to sign this authorization. Your refusal will **not** affect your ability to obtain treatment or payment. If the persons or entities authorized to receive the information are *not* health care providers or health plans covered by federal health privacy laws, they may redisclose the information and those laws would no longer protect the disclosed health information. Once you sign this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can *revoke* this authorization by delivering a dated and signed letter to our clinic addressed to:

Randall Wallace, MS, LP
199 Coon Rapids Blvd., #306
Coon Rapids, MN 55433

- When this box is checked, our organization will receive compensation for our use/disclosure of the information that is the subject of this authorization.

Individual's (or Legal Representative's) name (please print): _____

Individual's (or Legal Representative's) signature: _____

Date: _____

Capacity or authority of Legal Representative (if applicable): _____
(May be requested to provide verification of representative status)

Therapist's signature: _____ Date: _____