"Providing Community Based Services and Supports to Adults Living With Mental Illness"

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

☐ **PRS Family Peer Support Services**

10455 White Granite Dr Suite 400
Oakton, VA 22124
Ph. (703) 536-9000 Fax.(703) 448-3723 Email: fspreferrals@prsinc.org

As the person signing this authorization, I acknowledge that I am giving my permission to the below-mentioned person/class of persons to disclose and use protected health information. I further acknowledge that:

- I may refuse to sign this authorization.
- PRS, Inc. cannot condition the provision of treatment to me on my signing of this authorization.
- The original or a copy of this authorization shall be included with my original records.

These records (select only one):

☐ **ARE** protected by Federal Drug and Alcohol Confidentiality Regulations (42 CFR Part 2). If these records are protected by 42 CFR, Part 2, I understand a recipient is prohibited from making any further disclosure of this information unless expressly permitted by my written authorization, except as otherwise permitted by the Regulations. 42 CFR Part 2 also restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

☐ **ARE NOT** protected by Federal Drug and Alcohol Confidentiality Regulations (42 CFR Part 2). If these records are not protected by 42 CFR Part 2, I understand that the HIPAA Privacy Regulations require I be advised that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal HIPAA regulations.

Name of Individual:
Date of Birth: Youth Name and DOB:

With: (Name of Person, Agency or Organization)

Extent or nature of use/disclosure is limited to (indicate all that apply by placing "X" in box to left of description):

☐	**Psychological Evaluation**	☐	**Psychiatric Evaluation**	☐	**Diagnostic Report**
☐	**Psychosocial Evaluation**	☐	**Vocational Evaluation**	☐	**Medication Report**
☐	**Medical Evaluation**	☐	**Treatment Summary**	☐	**Admission Summary**
☐	**Discharge Summary**	☐	**Liaison/Collaboration**	☐	**Emergency Contact**
☐	**Other: (Describe here)**	Family Peer Support Partner Services			

Specific purpose or need for use/disclosure is (indicate all that apply by placing "X" in box to left of description):

☐	**Referral**	☐	**Service Coordination**	☐	**Other**: (list here)
☐	**Treatment Planning**	☐	**Discharge**		

This authorization will automatically terminate on_____(not to exceed one year) unless revoked by the undersigned.

This authorization (mark accordingly):

☐ **Does** ☐ **Does Not**

extend to information placed in my record after the date I signed this form.

_____ _____

Signature & Date Witness Signature & Date

☐ Self ☐ Guardian ☐ Authorized Representative

I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession of my health care records.

Date copy given to client: Signature: _____