Tina Champagne, OTD, OTR/L for Cutchins Care, LLC

Authorization for the Release of Protected Health Information

When you complete this form you are authorizing the disclosure/and or use of PHI, Protected Health Information. If you do not complete all information on this form, authorization may not be valid.

Client Name_____ Date of Birth_____

I hear by authorize Tina Champagne, OTD, OTR/L to :
___Release my health information to: ___Obtain my health information from:

1._____

2._____

3._____

Please provide name and contact information, including phone number, for providers listed above.

Purpose or Requested Use Of Disclosure
__Coordination of Care, assessment, treatment or follow up
___At the request of the client __ Insurance Authorization

Information that may be used or disclosed through the use of this authorization

___All Clinical Information ___Admission and Discharge Notes
Clinical Information from:_____ to: _____ Other_____

Signature_____Date_____

This authorization expires_____, or if not specified, one year from date of signing.

Information that may be used or disclosed through use of this authorization:

I specifically authorize the release of personal health information (PHI) relating to drug or alcohol abuse. I understand that my records are protected under federal regulation governing - Confidentiality of Alcohol and Drug Abuse Patients Records 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the Federal Regulations. The recipient of drug and/or alcohol abuse information disclosed as a result of this authorization will need my further written authorization to re-disclose this information.

Signature_____ Date _____

Notice of Rights and Other Information

I understand that I may take back or revoke this authorization in writing at any time, except to the extent Ellen Shaw-Smith has taken action on reliance on this authorization. I understand that to revoke this information, I understand that to revoke this information, I must provide it in writing to the above address. I also understand that if I refuse to sign it that it will not affect my ability to obtain treatment.