IRIS BEHAVIORAL HEALTH SERVICES

# AUTHORIZATION TO DISCLOSE PARTICIPANT HEALTH INFORMATION (PHI)
# HIPAA FORM 5.501

**Today's Date:**

**Patient Name:** **Patient DOB:**

**As required by HIPAA Privacy Regulations, protected health information may not be used or disclosed to a third party without participant authorization.**

I consent to, request, and authorize the following agencies to release any or all medical, social, psychological, or educational information regarding the above named person to IRIS Behavioral Health Services, LLC. In addition, I consent to, request, and authorize IRIS Behavioral Health Services, LLC to release any and all appropriate information in the treatment and/or diagnostic records of the above-named person to the following:

| Organization/ Provider | Name of Contact | Phone number of Contact |
|---|---|---|
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I understand that all such information becomes part of IRIS Behavior Health Services, LLC's records and will be utilized for planning services for the above-named person.

I understand that IRIS Behavioral Health Services, LLC preserves the confidentiality of client information, and releases information only according to policies based on the Federal HIPAA Privacy Regulations.

I understand that this Consent for Release of Information is valid for the period of time in which the above-named person is an active client of this agency (i.e., one who is receiving services planned, coordinated, delivered, or supervised by IRIS Behavioral Health Services, LLC). All or any part of the Consent for Release of Information is cancelled upon receipt of written notification from the undersigned.

**Effective Date of Authorization:**

**I understand I have the right to:**

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Participant Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
7. Receive a copy of this Authorization and understand that a photocopy is as valid as an original.

**Parent/Guardian Name:**

**Parent/Guardian Signature:**