David C. Mathis, Ed.D.
Counseling and Consulting Psychology

1134 Dow Street
Murfreesboro, TN
37130

615.624.4494
Fax: 615.823.2879
www.drdavidcmathis.com
drdcmathis@gmail.com

PATIENT DISCLOSURE AUTHORIZATION FORM

Patient Name: Date of Birth:

I authorize disclosure of my protected health information only in the specific manner, for the named reason, and to the specific individual(s) described below.

Specific description of information to be used or disclosed:
______progress notes only
______progress notes with therapy notes
______other:____

Reason for requested use or disclosure: ____
____
____

Name or the person or entity to which this practice will give/obtain my information: _______
____

This authorization will expire on the following date:___________________________________

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the provider, except if this practice has taken action relying on the consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosure.
- I will receive a copy of this completed and signed authorization form, upon request.

Signature:____Date:
Relationship to patient(if signed by a personal rep. of patient):

Witness:____Date: