

GATEWAY CHILDREN'S MENTAL HEALTH SERVICES  
397B SERPENTINE DRIVE, SPARTANBURG, SC 29303

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I am completing this form to allow the use and sharing of protected health information about:

Client's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I authorize Gateway to bill for services to Medicaid.

I authorize (therapist) \_\_\_\_\_ to use or disclosed information which may include education, medical, psychological, psychiatric, and social data which might be helpful in further assessment and treatment of the client and for this purpose.

TO/FROM:

Relation: \_\_\_\_\_

Phone/Address/Fax: \_\_\_\_\_

INITIAL & DATE below what you approve to be received or sent to the above listed place:

_____ Psychotherapy Notes	_____ Receive	_____ Send
_____ Medical Record	_____ Receive	_____ Send
_____ Correspondence	_____ Receive	_____ Send:
_____ Other	_____ Receive	_____ Send

Other Explanation: \_\_\_\_\_

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the Regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expired automatically as described below.

This authorization will be continual unless a time frame is specified. Specification of the date, event or condition upon which this consent expires: \_\_\_\_\_

\_\_\_\_\_  
Signature and Relationship to Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature and Relationship to Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist

\_\_\_\_\_  
Date