GATEWAY CHILDREN'S MENTAL HEALTH SERVICES
2406-A N MAIN ST, ANDERSON, SC 296251

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