**Michelle Shelfer RD|LDN|CEDRD**
**13 ½ Eagle Street, Office G, Asheville, NC 28806**
**Phone: (828) 337-5148**

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

**Client Name (printed):** ________________________________ **Date of Birth:** __________________

*Parent/Guardian/Legal Representative Name (minors only):* ____________________________________

**Health Care Provider, Person, Agency or Emergency Contact Information:** Please provide the name and contact information of the provider, person, agency or emergency contact (outside of Michelle Shelfer).

______________________________________________________________________________

Emergency Contact Name                Relationship to Client (i.e. PCP, Mother, etc.)

______________________________________________________________________________

Address, City, State, Zip                Phone                Fax Number

**I authorize Michelle Shelfer to communicate the following types of information to the provider, person or agency listed above by:**

☐Communicating the information as needed for the purposes identified below ☐Sending the information indicated below

☐Requesting the information indicated below

**Please indicate the *type of information* to be released (check all that apply):**

☐Documentation from a specific program or provider:
Program/Provider Name: __________________

☐Intake Evaluation/Assessment

☐Progress Notes/Treatment Plans

☐Financial Info/Scheduling

☐Discharge Summaries

☐Ongoing Verbal Communication

☐Other (please specify) __________________

**Please indicate the *purpose* of the release of information (check all that apply):**

☐Coordination of Care

☐Discharge and Continuation of Care

☐Client Request

☐Insurance

☐Litigation/Legal Purposes

☐Other (please specify):____________________

☐In addition, I authorize Michelle Shelfer to disclose my Protected Health Information to this individual as my Emergency Contact in situations in which Michelle Shelfer perceives a threat to my health, safety or well-being.

**Statement of Authorization**: I understand that my consent will remain in effect as long as I am a patient of Michelle Shelfer, unless and until I notify Michelle Shelfer in writing of any changes. I have been informed about the information that will be released, its purpose, and who will receive the information and I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand and authorize that the disclosure may include information on diagnosis and treatment, or any drug or alcohol abuse. I understand that personal health information, once disclosed, might be re-disclosed and is no longer protected by federal privacy regulations. I also understand that I may refuse to sign this authorization. Michelle Shelfer will not condition treatment, payment, enrollment or eligibility for services based on whether I sign this authorization.

**BY SIGNING MY NAME BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM.**

______________________________________________________________________________

**Client Signature (required if client is 13 years or older)**    **Parent/Guardian/Representative Signature**    **Date**

***Legal Representative*** *(where applicable): I am legally authorized to represent the client listed above and I understand that I may be asked to provide documentation to demonstrate this legal authority.*

______________________________________________________________________________

*Representative Signature*    *Relationship to Client/Legal Authority*    *Date*