GRAVEN AND ASSOCIATES, PLLC
PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this Authorization, I authorize _____, as my GRAVEN AND ASSOCIATES, PLLC behavioral health care provider ("PROVIDER"), to use and/or disclose certain protected health information (PHI) about me to:

Name: _____ **Address:** _____

Phone: _____ _____

Fax: _____ _____

This Authorization permits PROVIDER to use and/or disclose the following individually identifiable health information about me concerning my mental health treatment and care, including, if applicable, any information concerning substance abuse (drug or alcohol treatment) and HIV/AIDS-related information:

_____

_____

[Describe information to be used and/or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc. or state all information to be released/obtained]

The information will be used or disclosed for the following purpose _____

_____

[***If requested by the patient, the purpose may be "at the request of the individual."***]

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This Authorization will expire in one (1) year from the date of my signature below.

I understand that I do not have to sign this Authorization and that neither PROVIDER nor GRAVEN AND ASSOCIATES, PLLC will condition my ability to obtain treatment, enrollment or receive payment for health care services on whether or not I sign this Authorization. When my information is used or disclosed pursuant to this Authorization, it may be the subject of redisclosure by the recipient and may no longer be protected by federal law. I have the right to revoke this Authorization in writing except to the extent that PROVIDER has acted in reliance upon this Authorization prior to my revocation. My written revocation must be submitted to GRAVEN AND ASSOCIATES, PLLC at 8007 Lyndon Centre Way, Suite 101, Louisville, KY 40222, Attn: Dr. Jacquelyn Graven.

Signed by: _____ **Date:** _____
[Signature of Patient, Parent, Guardian or Authorized Representative]

Printed Name: _____ **Relationship/Authority:** _____

Patient Name: _____ **Patient Date of Birth:** ____/____/____

IF SIGNED BY GUARDIAN OR AUTHORIZED REPRESENTATIVE, PLEASE PROVIDE LEGAL DOCUMENTATION PROVING AUTHORITY UNDER STATE LAW (I.E., POWER OF ATTORNEY, LIVING WILL, GUARDIANSHIP PAPERS, ETC.)

PROVIDE PATIENT/PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE WITH SIGNED COPY OF AUTHORIZATION