# FamilyWise (formerly GENESIS II FOR FAMILIES)
## AUTHORIZATION FOR USE AND DISCLOSURE OF PRIVATE HEALTHCARE INFORMATION (PHI)

**Client (and/or Personal Representative) confirming this authorization to release PHI**

**Client Name:** _____ **Phone #:** _____

**Address:** _____ **DOB:** _____

**City/State/Zip:** _____ **SSN:** _____

**Personal Representative Information**

**Representative Name:** _____ **Phone #:** _____

**Address:** _____ **Fax #:** _____

**City/State/Zip:** _____ **Relationship to Client:** _____

**INFORMATION REGARDING THIS AUTHORIZATION**

**I understand that this authorization will expire:**

- ☐ **On _____ (MM/DD/YYYY) or one year from the date of signature below.**
- ☐ **All services at FamilyWise terminate.**

**I understand that I may revoke this authorization at any time by informing Genesis II for Families in writing and that if I choose to do so, my request to revoke will not affect any actions taken by Genesis II for Families before receiving my revocation.**

**I understand that if the person or entity receiving this information is not a health plan, health care or other provider covered by federal or state privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that Genesis II for Families ensures that its data, systems, and premises are secure in order to protect and preserve its PHI, services, and the safety of its staff and clients. I understand there may be situations that transportation of my PHI and record information is required to provide best coordination of my treatment. I am able to contact the Privacy Officer for further information on how transportation may apply to my client record.**

**AUTHORIZED USES AND DISCLOSURES**

**I hereby provide FamilyWise authorization with the party indicated below to (check all that apply):**

- ☐ **Exchange with**
- ☐ **Release to**
- ☐ **Obtain from**

**I hereby authorize FamilyWise to exchange / release / obtain information:**

- ☐ **Verbally only**
- ☐ **In written form only**
- ☐ **Electronic only**
- ☐ **All – verbally, in writing, and electronically**

**Person/Organization receiving/communicating the information:**

**Name:** _____ **Title:** _____

**Agency:** _____ **Phone #:** _____

**Address:** _____ **Fax #:** _____

**City/State/Zip:** _____ **Email:** _____

**AUTHORIZED USES AND DISCLOSURES**

**Description of individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained:**

- ☐ **Coordination of Services**
- ☐ **Third Party Authorization and Payment**
- ☐ **Insurance Payment**
- ☐ **Determination of eligibility for services**
- ☐ **Communication requiring legal issues**
- ☐ **Other _____.**

**The purpose of this release is (check all that apply):**

- ☐ **All / Entire Client Record**
- ☐ **Admission/Intake information/reports**
- ☐ **Diagnosis & Treatment Plan**
- ☐ **Progress/Case Notes**
- ☐ **Discharge Summary**
- ☐ **Psychological Assessment Reports**
- ☐ **Evaluation Reports**
- ☐ **Progress Review/Reports**
- ☐ **Educational Records (including IEP and IFSP)**
- ☐ **Medical/Physical History**
- ☐ **Medication records**
- ☐ **Demographic Information**
- ☐ **Information required for case coordination**
- ☐ **Billing Record/Statement**
- ☐ **Other _____.**

**Please note, FamilyWise will only release information generated within our agency.**

**SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT**

**I understand that, under most circumstances, a healthcare provider may not condition treatment on my signing this authorization. I may be required to sign an authorization if my treatment is provided solely for the purpose of creating PHI for disclosure to a third party. Under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.**

**INDIVIDUAL CLIENT'S SIGNATURE**

**I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the PHI described in this form with the people and/or organizations named in this form. A photocopy or fax of this authorization will be treated in the same manner as an original.**

**Signature:** _____ **Date:** _____

**If this authorization is signed by a personal representative for the individual client:**

**Personal Representative's Name:** _____

**Signature:** _____ **Date:** _____

**Relationship to the Client:** _____

**YOU HAVE A RIGHT TO A COPY OF THIS FORM AFTER YOU SIGN IT. JUST ASK FOR ONE.**