Sage

HIPPA Release of Information

Authorization Form

I, _____ (hereinafter "client"), DOB: _____ hereby authorize Sage (hereinafter "Sage") and its affiliates, its employees and agents (collectively "Sage"), to exchange and disclose mental health information including information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number with:

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

This Authorization **excludes** the following information about me:

_____

_____

A check here ___ indicates that I am not excluding any information about me.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my guardian's signature below and shall expire the earlier of _____ or (check here) ____one month after the end of treatment with Sage.

I understand that I have a right to revoke this authorization by providing written notice to Sage. However, this authorization may not be revoked if Sage has taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect the provision of treatment.

Name of client: _____

Signature of client: _____

Date: _____

Name of parent or guardian if client is a minor: _____

Signature of parent or guardian if client is a minor: _____

Date: _____