AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: ____
First Name Middle Name Last Name

Date of Birth: ___/___/______

Date Authorization Initiated: ___/___/_____

Authorization initiated by :____
Name (Client, Provider or Other)

INFORMATION TO BE RELEASED: Check all that apply.

___ Written Notes from a Session

____ Communication about content of a session

___ Communication about Goals of a session

____ Confirmation of attendance at a session

Other (describe information in detail) ____

____

The purpose of releasing this information:____

____

Person Authorized to Make the Disclosure

____
Name

____
Address

____
City, State

Person Authorized to Receive the Disclosure

____
Name

____
Address

____
City, State

This Authorization will expire on ___/___/_____ or upon the happening of the following event:

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I also understand that I have the right to revoke this authorization at any time either in writing or by verbal confirmation.

Signature of Client: ____ Date ________________