Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____ __First Name _____MI ___

DOB: ___/___/____

Client Address: _____

Client Home Phone: _____Cell/Work Phone: _____Client Email:_____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____

Phone: _____Address: _____

Date of Authorization: ___/___/_____ Authorization to expire on ___/___/_____

Information to be Released

□ My entire mental health record. □ Only those portions pertaining to: _____

□ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

□ Other: _____

Purpose of Information Release

_____

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. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____Signature Date: _____

If signed by a personal representative:
(a) Print your name: _____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:
_____
_____
_____