

 

AUTHORIZATION FOR USE OR DISCLOSURE OF

PROTECTED HEALTH INFORMATION

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1. Client's name:

First Name

1. Date of Birth: / /

Middle Name

Last Name

1. Date authorization initiated: / /
2. Authorization initiated by:

Name (client, provider, or other)

1. Information to be released:

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 (describe information in detail):

1. Purpose of Disclosure: The reason I am authorizing release is:

My request

* @

Other (describe):

1. Person(s) Authorized to Make the Disclosure:
2. Person(s) Authorized to Receive the Disclosure:
3. 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. 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 of the Patient:

Signature of Personal Representative: Relationship to Patient if Personal Representative: Date of signature:



 

