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**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 Address: _____

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 ___/___/___ or upon the happening of the following event: _____

Information to be Released

(Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)

My entire mental health record

Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)

Authorization for Psychotherapy Information 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

Further mental health care

Payment of insurance claim

Legal investigation

Applying for insurance

Vocational rehab, evaluation

Disability determination

At the request of the individual

Other (specify): _____

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/guardian:

Print your name: _____

Indicate your relationship to the client and/or reason and legal authority for signing:

Legal authority:

Parent

Legal guardian

Power of Attorney

Patient is:

minor

incompetent

disabled

deceased