Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name: _____ First Name: _____ DOB: _____

Client Address: _____ City/State: _____ Zip: _____

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: _____

Address: _____ City/State: _____ Zip: _____

Phone: _____

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 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:

☐ 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: Print your name: _____
Indicate your relationship to the client and/or reason and legal authority for signing:
Patient is: ☐ minor ☐ incompetent ☐ disabled ☐ deceased
Legal authority: ☐ parent ☐ legal guardian ☐ representative of deceased