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Authorization for Use or Disclosure of Protected Health Information

1. Client's Name _____
   First Name Middle Name Last Name
2. Date of Birth: ____/____/____
3. Date Authorization Initiated: ____/____/____
4. Authorization Initiated by: _____
   Name (client, provider or other)
5. Information to be released:

   ☐ Authorization of Psychotherapy Notes ONLY

   ☐ Other (describe information in detail): _____

   _____

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

   ☐ My Request

   ☐ Other (describe): _____

7. Person(s) Authorized to make Disclosure:_____
8. Person(s) Authorized to receive Disclosure:_____
9. This Authorization will expire on __/__/__ or upon the happening of the following event:
   _____

Authorization & 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 Client: _____ Date:_____

Signature of Client:_____ Date:_____

Signature of Therapist: _____ Date:_____