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# Authorization for Use or Disclosure of Protected Health Information

## Client Information

Last Name: ______________________ First Name_____________________ MI_____
Address: ________________________________________________________________
Home Phone:_____________________ Cell/Work Phone: ______________________
Email Address:_______________________________________ DOB:___/___/_____

## 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: ____________________________________________________________
Phone: ______________________ Fax: _______________________

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
☐Only those portions pertaining to: ______________________________________________

## Recipient Information

(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/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
Patient is:☐minor ☐incompetent ☐disabled ☐deceased - Legal authority: ☐parent ☐legal guardian