Authorization for Use and Disclosure of Protected Health Information

Release TO: Name: ____
Address: ____
City: ______________________________ State: ______ Zip: _________
Phone #: ____

Release FROM: Provider/Facility: ____
Address: ____
City: ______________________________ State: ______ Zip: ________

Client Identification:
Name: ______________________________
__________________________ Date of Birth: ____________
Address: ____
City: ______________________________ State: ______ Zip: ________
Phone #: ____

Purpose of Request:
___ Request of client ___ Billing/Payment ___ Treatment or Consultation
___ Attorney/Legal ___ Other

I Request My Records be Provided:
___ Verbally/by phone ___ Paper (hard copy) ___ Electronically via Email ___ Other
Email Address: ____

Information to be Released- Covering the Periods of Health Care (must check one)
___ Any and All (through date of signature of this authorization)
___ From (Date): ____________________________ To (Date): ____________________________

Please check the type of information to be released:
___ Complete Clinical Record ___ Assessments ___ Discharge Summary ___ Treatment Plan
___ Appointment History ___ Billing Statement ___ Confirm session attendance
___ Other (Please specify) ____

This information is being released for the following reasons: ______________________________
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_____I understand that this release may include information regarding drug and alcohol abuse and treatment, as well as psychological and psychiatric information.

_____ I understand that the information to be released is protected under state and federal laws that do not permit redisclosure without my further consent.

_____ I understand that I may revoke this authorization at any time, except for information that has been disclosed as a result of this authorization prior to its revocation.

_____ This consent will expire________days from the date it is signed.

Signature of Client Date

Signature of Client Date

Signature of Parent, Guardian, or Authorized Representative Date

Signature of Witness Date