

**AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
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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 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 (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 the Disclosure:**

8. **Person(s) Authorized to Receive the Disclosure:**

9. **This Authorization will expire on** __/__/__ **or upon the happening of the following event:**

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 redisclosed 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 the Patient: _____

Signature of Personal Representative: _____

Relationship to Patient if Personal Representative: _____

Date of signature: _____

