Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____ First Name_____ MI_____
DOB: _____/_____/_____
Client Address_____
Client Home Phone: _____
Cell/Work Phone: _____
Client Email Address: _____

Recipient Information

I, _____, do herby authorize _____
to release a copy of my mental health information to the person or facility below.
Name of person /facility to receive medical information: _____
Phone: _____
Address: _____

Date of Authorization: _____/_____/_____
Authorization to expire on _____/_____/_____ or upon the happening of the following event:
_____

Information to be Released

□ My entire mental health record

□ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)
□ Other: _____

Purpose of Information Release

☐ Coordinate mental health care ☐ 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.

_____ _____
(Signature) (Date)

If signed by a personal representative:
(a) Print you name: _____
(b) Indicate your relationship to the client and/or reason and legal authority for signing:
Patient is: ☐ minor
Legal authority: ☐ parent ☐ legal guardian