Authorization for use or disclosure of protected health information

Client's name	First name: Middle name: Last name:
Date of Birth:	Month: / Day: / Year:
Date authorization initiated	Month: / Day: / Year:
Authorization initiated by	Name: Specify client, provider, or other
Information to be released:	❑ Authorization for Psychotherapy Notes only ❑ Other (describe information in detail):
Purpose of Disclosure: The reason I am authorizing release is:	❑ My request ❑ Other (describe):
Person(s) Authorized to Make the Disclosure	
Person(s) Authorized to Receive the Disclosure:	
This Authorization will expire on: / / or upon the happening of the following event:	❑ Month: / Day: / Year: ❑ Upon the following event (describe):

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 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 the Patient: _______________________________

Signature of Personal Representative: _______________________________

Relationship to Patient if Personal Representative" _______________________________

Date of signature: Month: ___ / Day: ___ / Year: ___