RELEASE OF HEALTH INFORMATION

Authorization for Use or Disclosure of Protected Health Information

1. Date (Date Authorization initiated): _____

2. Patient's Name: _____
   First Middle Last

3. Patient's Date of Birth: _____

4. Authorization initiated by: ☐ Patient ☐ Guardian ☐ Provider ☐ Other: _____

5. Information to be released:

   ☐ 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 desired information in detail): _____

   _____

6. Purpose of Disclosure:

   ☐ My request ☐ Other (described): _____

7. Person(s)/Organization Authorized to MAKE the Disclosure: _____

   Phone: _____ Address: _____

8. Person(s)/Organization Authorized to RECEIVE the Disclosure: _____

   Fax: _____ Phone: _____

   Address: _____

9. This Authorization will expire on (date): _____ OR upon the occurrence 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 pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by stated laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____

Signature of Patient OR Patient's Legal Guardian, if applicable Relationship of Legal Guardian, if applicable

_____

Date