AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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: _____