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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1.Client's name: ____
2. Date of Birth: ___/___/___
3. Date authorization initiated: ___/___/___
4. Authorization initiated by: ____
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: __MEAGAN RAE SEGAL, LCSW-R
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 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: ____
Date of Signature: ____________________________