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):

   CONTINUITY OF CARE_____

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 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: _____