Michael R. Hemenway, MA, LMFT
1 Kingston Drive, Unit 1, Ansonia, CT 06401
203-446-6562

Authorization For Use/Disclosure Of Health Information

Client's name: _____ Clients D.O.B: _____

Client's Address: _____

Authorization for use and disclosure of information:
I hereby authorize Hemenway Family Therapy and Wellness, LLC to use or disclose my protected health information (PHI) during the term of this authorization to the recipient(s) that I have identified below:

Recipient:
I authorize my healthcare information to be released to the following recipient(s):

Provider Name: _____

Provider Address: _____

Term:
I understand that this Authorization will remain in effect for the entire duration of

By signing this form, I authorize you to release confidential health information about _____ (client), including but not limited to psychotherapy records, progress of treatment, or any records pertaining to the client mentioned above.