TAMMY JO VROOM, MSW
LICENSED CLINICAL SOCIAL WORKER

AUTHORIZATION FORM

For use of disclosure of identifiable health information

I hereby authorize Tammy Jo Vroom, Counseling, LLC, to use or disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive my information is not a health care provider or health plan, the information releases may no longer be protected by federal privacy regulations.

_____ _____

Client's Name/Family Name **Client's D.O.B.**

Information to be RELEASES BY:
Organization/Provider/Phone/Fax: _____

Address/City/State/Zipcode: _____

Information to be SENT TO:
Organization/Provider/Phone/Fax: _____

Address/City/State/Zipcode: _____

Information to be released:

- ○ Outpatient Visits
- ○ Initial Assessment
- ○ Psychological Assessment
- ○ Discharge Summary
- ○ School Records
- ○ Other (Specify): _____

Purpose of this use/disclosure:

- ○ Coordination of treatment services
- ○ Client Request
- ○ Other (Specify):_____

This authorization will expire on: _____Method of disclosure_____

I understand that my health care and the payment of my health care will not be affected if I do not sign this form. In addition, I understand that I may inspect or request a copy of my protected health information to be used or disclosed and that I may revoke this authorization at any time by notifying the providing organization in writing. I also understand that my written notification will not have any affect on actions taken before the providing organization received the revocation.

_____ _____
Print Name or Parent or Legal Representative Relationship to Client

_____ _____
Signature Client, Parent or Legal Representative Date

_____ _____
Signature of Witness Date

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