Megan Gillespie, LCSW

PLLC

Authorization for Release of Protected Health Information

CLIENT INFORMATION:

Name: _____

Address: _____

City, State, Zip Code: _____

Date of Birth: _____

I, _____ (client), consent to the release of privileged information and waive the privilege of confidentiality for medical and mental health care, and authorize Megan Gillespie, LCSW, PLLC to communicate with the individual(s) listed below to exchange information for the purpose of clarifying and enhancing my care and treatment.

Please check one or both of the following:
To obtain from ____ To disclose to ____

Name of Person/Facility: _____

Address: _____

City, State, Zip Code: _____

Phone/Fax Number: _____

Relationship to client: _____

SPECIFIC INFORMATION AUTHORIZED (Please check all that apply):

( ) Dates/Times of Service ( ) Treatment Plan(s) ( ) Progress Notes

( ) Evaluation/Assessment ( ) Diagnostic Impression ( ) Verbal Discussion of Care

( ) Other (Please specify): _____

PURPOSE OF AUTHORIZED INFORMATION (Please check all that apply):

( ) Planning appropriate psychotherapy treatment and/or program
( ) Continuity of Care
( ) Referral
( ) Other (Please specify): _____

I authorize the use/disclosure of the information described above to the person identified to fulfill the purpose identified in this document.

I understand that my records are protected under federal and state laws, and cannot be disclosed without a written consent, except as specifically stated by law. This authorization is entirely voluntarily. Unless otherwise specified, this authorization will expire one year from the date of signature. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Client Signature Date

_____ _____
Megan Gillespie, LCSW, PLLC Date