PROVIDENCE SERVICE, LLC

PHONE # 615-668-4485

FAX

Authorization for Release of Protected Health Information

Client's Name :

_____

Last First

M.I.

Date of Birth: _____/_____/_____

Date authorization initiated: _____/_____/_____

Date of Expiration: _____/_____/_____

Authorization initiated by_____

Name (client, provider, or other)

Purpose of Disclosure: The reason I, _____ or my Legal Guardian is authorizing this release of Information is:

_____ To provide copies of my medical records ONLY

_____ For other Reasons described as follows:

_____

_____

_____

_____

_____

_____

I, _____, authorize this Release of Information to:

Providence Service, LLC

Phone #" 615-668-4485 or 480-590-8162

Authorization and Signature: I authorize the release of my, or my dependent's confidential protected

health information, as described in the 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/Legal Guardian: _____ Today's Date: _____

Name of Legal Guardian, if Applicable:

_____

Relationship to Patient if Legal Guardian:

_____