AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
Person Authorized to Make Disclosure: Lori Chris Cannida, MS, LPC/ Phone: (336) 391-8720

1. Client's name: _____
First Name Middle Name Last Name

2. Date of Birth: ___/___/___

3. Date authorization initiated: ___/___/___

Purpose of release: ____ Requested by client
____ Requested by other: _____

4. 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):

- ❑ Psychosocial Information/History
- ❑ Record of Attendance
- ❑ Treatment Plan
- ❑ Treatment Summary

Information released may be in the following form(s):
- ❑ Written Records
- ❑ Verbal (by Phone or In-Person Consult)

5. Person Authorized to Receive Disclosure:

_____

_____

_____

Phone: (___)_____

This Authorization will expire on ___/___/___ or upon the happening of the following event:

- ❑ Client Withdrawal of Authorization
- ❑ Case Closure or Termination of Services by either party (client or L. Chris Cannida, LPC)

Authorization and Signature: I authorize the release of my 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 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: _____ **Date: ___/___/___**

Signature of Legal Guardian: _____ Date: ___/___/___