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AUTHORIZATION FOR RELEASE AND SHARING OF PROTECTED HEALTH INFORMATION

I, (print name), ________________ (date of birth), hereby authorize ____ (enter specific identification of person or entity authorized to make disclosure) to release/share my health information, as specified below, to ________________________________. I authorize the following information to be released: (enter a specified description, including identification of portions of records to be released, i.e., narrative summary, psychological evaluation, progress notes, history, and/or time periods of treatment records to be released.)

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This authorization shall be in force and effect until ________________ (date) or until 30 days after termination of your services, at which time this authorization to use or disclose this protected health information expires. I understand 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.

___________________________ ________________

Signature Date