Amy L. Luzar, MSSA, LISW-S. 19910 Malvern Rd. Rm 221. Shaker Hts., OH 44122. 216.973-9976.

Amy Luzar, MSSA, LISW-S

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Instructions: This is a fillable PDF. You may download and open it using Adobe Acrobat or a browser, complete all fields, and save your changes. At the end of this form, **digitally sign or type in your name.** Once finished, email the completed form to amy@amyluzar.com

I, _____, hereby authorize: Amy Luzar, LISW-S to use, obtain, and share mental health treatment information and records obtained in the course of psychotherapy treatment of you, my client, from/with:

NAME		PHONE #	
ADDRESS			

I understand that I have the right to receive a copy of this authorization. I understand that I have the right to revoke this authorization at any time, that such revocation must be in writing, and received by Amy Luzar, LISW-S, to be effective. This will prevent further releases after this time but cannot change the fact the some information may have been sent or released before that date. Also, you may have the right to inspect and receive a copy of the health information described in this authorization.

The disclosure of information and records is required for the following purposes:

_____
_____
_____

The information used or disclosed in this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy rule, although applicable Ohio law may protect such information.

This authorization shall remain valid until _____

☐ checking this box indicates I intend to use my typed name and the date as my signature

Signature of Client (if over 18):_____ Date:_____
Printed Name:_____

Signature of Parent/Guardian:_____ Date:_____
Printed Name:_____