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Psychotherapist
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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

2. Date of Birth: ___/___/___

3. Date authorization initiated: ___/___/___

4. Authorization initiated by:
____

5. Name (client, provider, or other) Information to be released:
- -------♦ Authorization for Psychotherapy Notes ONLY
- -------♦ Other (describe information in detail):
____
____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my 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:____

Signature of Personal Representative:____

Relationship to Patient if Personal Representative:____

Date of signature: ____