Authorization for Use or Disclosure of Protected Health Information

Client Information:

Client Last Name_____ First Name _____ MI ____

DOB:___/___/____ Client Email Address: _____

Client Address_____

Client Home Phone: _____ Cell/Work Phone: _____

Recipient Information:

I, _____, do hereby authorize Claire Sebastian, LCSW to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____

Phone: _____Address: _____

Date of Authorization: ___/___/____ Authorization to expire on ___/___/____ or upon the

happening of the following event: _____

Information to be Released (Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)

____ My entire mental health record ____ Only those portions pertaining to:

_____
(Specific provider name and/or dates of treatment)

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.)

Purpose of Information Release:

____Further mental health care ____Applying for insurance
____At the request of the individual ____Payment of insurance claim

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 Date

(a) Print your name: _____
(b) Indicate your relationship to the client and/or reason and legal authority for signing:
____ Self ____ Parent ____ Legal Guardian