AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive my information is not a health plan or health care provider, that organization my also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Provider (Who is releasing information?)

Name: _____ Phone: _____

Address: _____ Fax: _____

Receiver (Who is receiving information?)

Name: _____ Phone: _____

Address: _____ Fax: _____

Information to be Disclosed

☐ Verbal Communication ☐ Therapy Notes ☐ Summary of Contacts/Treatment

☐ Coordinate Services ☐ Other: _____

Dates of Service

From date: _____ To date: _____

Expiration Date

I understand this authorization will expire in **one year** unless otherwise revoked.

Revocation

I understand that I may revoke this authorization at any time by signing a Revocation of Authorization form.

_____ _____

Signature of patient or patient's legal representative *Date*

_____ _____

Printed name of legal representative *Relationship*

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