AUTHORIZATION OF PROTECTED HEALTH INFORMATION

Client's name (please print): _____
First Name Middle Name Last Name

Date of Birth:_____(MM/DD/YY)

Today's Date:_____(MM/DD/YY)

Authorization Initiated by:_____
Name (client, provider, other)

Information to be Shared:

- all information related to treatment care of client
- selected information related to treatment care of client (please explain in detail)

_____

_____

Persons authorized by this consent to receive information:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

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 Client:_____

Signature of Parent/Guardian (if under 18):_____

Date of Signature:_____(MM/DD/YY)

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