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 Released:

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

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Persons Authorized by this consent to receive information:

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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