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Release of Information

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Authorization for Use or Disclosure
of Protected Health Information

Client Information

Last Name_____ First Name _____MI ___

DOB:___/___/____ Client Address_____
_____

Client Home Phone: _____ Cell/Work Phone:_____
Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release mental health information to the person or facility below.

Name of person/facility to receive or exchange information:

Phone: _____
Address:_____
Date of Authorization: ___/___/_____
Authorization to expire on ___/___/_____ or upon the happening of the following event:
_____

Authorization and Signature I authorize the release of my 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.

Signature _____ Date:_____

Print your name: _____