Authorization to Disclose (Release) Protected Health Information

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*Client name and birthdate:_____

Information requested to be disclosed by:_____

Information requested to be disclosed to: _____

What kind of Protected Health Information do you want released? Check all that applies.

___ Information from clinical sessions and written data/documentation
___ Information from specific session dates:
_____
___ Specific information (please specify):
_____
___ Copies of clinical records, including Progress Notes, Intake Notes, Assessments
___ Information re: substance use problems, chemical dependency assessment or treatment
___ Information re: testing, diagnosis, treatment of HIV/AIDS

- I/We may revoke this authorization in writing. If I/We revoke this authorization, it will not affect any actions already taken based upon this authorization.
- Once disclosed, Protected Health Information may be subject to re-disclosure by the recipient and may no longer be protected under health information privacy laws.
- I/We acknowledge that is authorization was fully explained to me/us and is signed by my/our free will.
- This authorization will automatically expire one year from the date signed, unless otherwise specified.

Signature: Date:
Printed Name:

*Name of Parent(s) or Guardians if client is under the age of 13

_____

Signature(s): Date: