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Authorization to Disclose/Exchange Confidential Health Information

(All information on this form is protected with encryption and HIPAA compliance)

Client Name: _____ Date of Birth: _____

My Therapist, _____ is authorized to (check all that apply):

_____ Release or disclose records and/or information

_____ Obtain records and/or information

_____ Mutually discuss and exchange records and/or information

The above should only be shared with: _____
(Name and capacity of individual or organization)

_____
(Address line 1)

_____
(Address line 2)

_____
(Phone)

The specific uses and limitations of the of the types of medical information to be disclosed are:

_____ Symptoms
_____ Summary of Treatment
_____ Progress
_____ Medical Record
_____ Clinical Test Results
_____ Other

The disclosure of information authorized by Client is required for the following purpose:

_____

This authorization will remain valid until: _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing by me. I understand that I have the right to revoke this authorization at any time. However, this revocation will not extend to information that was already obtained or released prior to the revocation. I also understand that such revocation must be in writing and received by my therapist to be effective. In addition, I understand that my therapist cannot condition my treatment upon me signing this authorization, and that I have a right to refuse to sign. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected, although applicable law may protect such information.

_____ _____
Client's Signature or Signature of Representative *Date*

If signed by other than Client, please indicate the relationship between Client and his/her representative