Authorization for Release of Information Form

I (client) _____ hereby authorize use or disclosure of protected health information about me as described below.

The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

_____

_____

_____

Specific description of information to be released (and date(s) of service):

_____

_____

_____

The information to be released will be used for the psychotherapeutic treatment of the client(s) in a manner that is consistently with all ethical and legal guidelines.

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying my therapist in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on _____, or 1 (one) year after the date of said authorization.

_____ ___/___/___ _____

Signature Date SS Number