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| --- | --- | --- | --- |
| AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION | | | |
|  | | | |
| Client’s Name: Date of Birth: | | | |
| Address: | | | |
| Phone #: | | Date Initiated: | |
|  | | | |
| 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. | | | |
|  | | | |
| Name/Agency: | | | |
| Phone #: |  | |  |
| Relationship to Client: | |  | |
| Purpose for Release: |  | |  |
| Specific Information to be released: | |  | |
| CLIENT SIGNATURE: | | | |
| WITNESS SIGNATURE | | | |
| \*You have the right to revoke this release at any time. | | | |
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