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| AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION |
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| Client’s Name: Date of Birth: |
| Address:  |
| Phone #:  | Date Initiated: |
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| 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.  |
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| 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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