

# Authorization for Use or Disclosure of Protected Health Information

## CLIENT INFORMATION

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Address \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

## RECIPIENT INFORMATION

I, \_\_\_\_\_, do hereby authorize Lisa Geraud to release my health information to the person or facility below.

Name of recipient of health information \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of authorization \_\_\_\_/\_\_\_\_/\_\_\_\_

Authorization to expire on \_\_\_\_/\_\_\_\_/\_\_\_\_ or upon the event of concluded treatment \_\_\_\_

### Released Information

\_\_\_ entire mental health record

\_\_\_ portions of mental health record related only to \_\_\_\_\_

\_\_\_ authorization for psychotherapy notes only (Important: If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information)

\_\_\_ other \_\_\_\_\_

### Purpose of Information Release

\_\_\_ request of the individual

\_\_\_ additional mental or nutrition health care

\_\_\_ payment of insurance claim

\_\_\_ vocational evaluation

\_\_\_ disability evaluation

\_\_\_ applying for insurance

\_\_\_ legal inquiry

\_\_\_ other: \_\_\_\_\_

## AUTHORIZATION AND SIGNATURE

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. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

\_\_\_\_\_  
**signature**

\_\_\_\_\_  
**date**

If signed by a personal representative:

Print name \_\_\_\_\_

Indicate your relationship to the client and/or reason and legal authority for signing

Client is \_\_\_ minor \_\_\_ incompetent \_\_\_ disabled \_\_\_ deceased

Legal authority \_\_\_ parent \_\_\_ legal guardian \_\_\_ representative of deceased

