HIPAA Authorization for Release of Information Form

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

(NAME)_____(DOB)_____

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 (must include 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 at **PhIIRST** 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.

***THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING*.**

_____ ___/___/_____ _____
Signature Date SS Number