BRANCHES

Recovering Hope • Restoring Lives

AUTHORIZATION FOR USE OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Client's Name: _____
First Name Middle Name Last Name

Date of Birth: _____ /_____ /_____

Date Authorization Initiated: _____ /_____ /_____

Authorization Initiated By: _____

Information to be released:

☐ **Authorization for Psychotherapy Notes ONLY** (Important: If this authorization is for Psychotherapy Notes, you may not use it for authorization for any other type of protected health information.)

☐ **Other** (describe in detail below):

Purpose of Disclosure: The reason I am authorizing release is:

☐ **My Request**

☐ **Other** (describe in detail below):

Person(s) Authorized to Make the Disclosure: _____

Person(s) Authorized to Receive the Disclosure: _____

This Authorization will expire on _____ /_____ /_____ or upon the happening of the following event:

_____

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.

_____ _____
Client / Guardian Signature **Date**

_____
Relationship to Client (If signing as guardian)

_____ _____
Signature of Witness **Date**