AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: ___/___/___

Authorization initiated by: _____Date initiated: ___/___/___

Information to be released:
☐ 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 (describe information in detail): _____

_____

Purpose of Disclosure: The reason I am authorizing release is:
☐ My request
☐ Other (describe): _____

Person(s) Authorized to Make the Disclosure: ☐ Nathan Perron ☐ Other: _____

Person(s) Authorized to Receive the Disclosure:
_____

This Authorization will expire on ___/___/___ or at any time prior to this date, when I have provided written documentation to cancel this authorization.

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 Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____