CENTER FOR PSYCHOLOGICAL WELLNESS, INC.
954-345-5644

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

CLIENT/GUARDIAN INFORMATION

CLIENT NAME	______________________	DATE OF BIRTH	__________
GUARDIAN NAME	______________________	DATE OF BIRTH	__________
HOME ADDRESS	______________________	PHONE #	__________
		E-MAIL	

AUTHORIZATION INFORMATION

Date of Authorization: ____________ Authorization initiated by ☐ client ☐ provider ☐ other

Name of person providing this authorization:____

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: ____

Person(s) Authorized to Receive the Disclosure: ____

This Authorization will expire on (date)________________________ or upon termination of counseling sessions.

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:** ____________________

Name of Client/Guardian: ______________________________ **Relation to client:** ____________