REBECCA J. TRIMBLE, MSW,LCSW **CLINICAL SOCIAL WORKER**

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:_____
Name (client, provider or other)

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:_____

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

☐ My request

☐ Other:_____

Person Authorized to Make Disclosure:_____

Person Authorized to Receive Disclosure:_____

This Authorization will: ☐ Not Expire ☐ Expire on___/___/___

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, and that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions.

Signature of Patient or Personal Representative:_____

Relationship to Patient if Personal Representative:_____

Date of signature: _____