AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Client's name: _____
   First Name Middle Name Last Name

2. Date of Birth: ___/___/___

3. Date authorization initiated: ___/___/___

4. Authorization initiated by:
   _____
   Name (client, provider, or other)

5. 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): N/A

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

   ☐ My request

   ☒ Other (describe): For Therapist to bill insurance

7. Person(s) Authorized to Make the Disclosure:

8. Person(s) Authorized to Receive the Disclosure:

9. This Authorization will expire on ___/___/___ or upon the happening of the following event: end of Treatment

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 of the Patient:

_____

Signature of Personal Representative:

_____

Relationship to Patient if Personal Representative:

_____

Date of signature: _____