Authorization for Use or Disclosure of Protected Health Information

Client Information: **DOB: ____/____/_____**

Last Name_____ First Name _____MI _____

Client Address: _____

Client Phone: _____ (circle which) Cell / Work / Home

Can messages/texts be left on this phone? (Yes/No) If not, alternate #? _____

Client Email Address: _____

I, _____, do hereby authorize **Laura Hout, LMFT 85481**

to discuss my mental health information with the person or facility listed below **for the coordination of treatment.** (This is not a release for written health information records. That must be done separately.)

Name of person or facility: _____

Phone: _____ Address: _____

Date of Authorization ____/____/_____ 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 this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is 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:**____/____/_____

PAGE TWO (if needed)

Authorization for Use or Disclosure of Protected Health Information

If signed by a personal representative:

(a) Print your name: _____

(b) Indicate your relationship to the client and/or the reason and legal authority for your signing:

(Circle)

Patient is: minor, incompetent, disabled, deceased

Legal authority: parent, legal guardian, representative of deceased