Negeen Moussavian
THERAPY

Authorization for Use or Disclosure of Protected Health Information Form

Client's Name:

_____ _____
first name *last name*

Date of Birth: ____ /_____ /_____

Date authorization initiated: ____ / ____ / _____

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

Information to be Released:

- ☐ Summary of treatment to date
- ☐ Report
- ☐ Other: *(describe information in detail)*

_____

_____

_____

Purpose of Disclosure:

- ☐ Coordination of Care
- ☐ Continuity of Care
- ☐ Other: _____

Persons authorized to make Disclosure: _____

Person authorized to receive Disclosure: _____

Other Relevant/Necessary Information:_____

_____

Method of Disclosure:

- ☐ Written: _____
- ☐ Verbal: _____
- ☐ Electronic: _____

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This 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 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: _____

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