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**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION** (Page 1 of 2)

1. Client's Name: _____/____/____
   First Name Middle Initial Last Name Date of Birth
2. Date authorization initiated: ___/___/___
3. Authorization initiated by: _____
   Name (client, provider, or both)
4. Information to be released:
   - ☐ Authorization for any applicable information concerning my mental health history, progress and goals.
   - ☐ Other (describe information in detail):
     _____
5. Purpose of Disclosure: The reason I am authorizing release is:
   - ☐ My request
   - ☐ Other (describe):

   _____
6. Person(s) Authorized to Make the Disclosure:_____
7. Person(s) Authorized to Receive the Disclosure: _____
8. 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 in 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:_____/_____/_____
Today's Date

Signature of Personal Representative:_____(Relationship)