Talk Time

Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____ First Name _____MI _____

DOB: ___/___/____ Client Address: _____

Client Phone: _____; Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____

Phone: _____ Address: _____

Date of Authorization: ___/___/_____; Authorization to expire on ___/___/_____ or upon the happening of the following event: _____

Information to be Released

[ ] My entire mental health record; [ ] Only those portions pertaining to: _____

[ ] 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 Information Release:

[ ] Further mental health care

[ ] Payment of insurance claim

[ ] Legal investigation

[ ] At the request of the individual

[ ] Applying for insurance

[ ] Vocational rehab, evaluation

[ ] Disability determination

[ ] Other (specify): _____

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.

_____ _____

Signature Date