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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1.Client's Name: _____

2. Date of Birth: ___/___/___

3. Date authorization initiated: ___/___/___

4. 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):_____

5. Person(s) Authorized to Make the Disclosure: __MEAGAN RAE SEGAL, LCSW-R

6. Person(s) Authorized to Receive the Disclosure: _____

7. This Authorization will expire on ___/___/___ or upon discharge

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: _____

Date of Signature:_____