



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ SS# \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

I, the undersigned patient or legal guardian, hereby authorize \_\_\_ verbal and/or \_\_\_ written information to be released by:

Name of Releasing Provider \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

TO: \_\_\_\_\_

Name of Provider/Hospital/Third Party \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

Fax \_\_\_\_\_

Information to be released:

- \_\_\_ Progress Notes \_\_\_ Discharge & Aftercare Plan
\_\_\_ Treatment Planning \_\_\_ Psychosocial
\_\_\_ Psychiatric Evaluation \_\_\_ Medication Record
\_\_\_ Psychological Testing \_\_\_ Other \_\_\_\_\_

Release of information for the following purpose(s):

- \_\_\_ Treatment/Consultation \_\_\_ Patient Request \_\_\_ Billing/Claims \_\_\_ Attorney
\_\_\_ Other \_\_\_\_\_

- I understand that this authorization is voluntary and that treatment by Jennifer Morgan M.A., LPC, BCPC cannot be conditioned on signing of this authorization.
I understand there may be a charge, payable in advance, for the copying and conveyance of records released.
I understand that this authorization can be withdrawn by me, in writing, at any time. I cannot, however, take exception to actions that have taken place before I withdrew my consent.
I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected. Jennifer Morgan is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
I understand that the information that is being released is from records whose confidentiality is protected by state and federal law.

Patient/Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_

Witness & Title \_\_\_\_\_

Date \_\_\_\_\_

Expiration Date: 60 days after signature