AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client's Name: _____ Date of Birth: ___/___/___
(First, Middle, Last) MM DD YY

Authorization Initiator Name: _____ Date Authorization Initiated: ___/___/___
(Client, Provider, or Other) MM DD YY

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.)*

_____

Purpose of Disclosure *("The reason I am authorizing release is...")* :

- ☐ My Request
- ☐ Other *(Describe)*

_____

Person(s) Authorized to Make the Disclosure:

_____
(If listing multiple, separate by comma.)

Person(s) Authorized to Receive the Disclosure:

_____
(If listing multiple, separate by comma.)

This Authorization will expire on: ___/___/___ **- or -** upon the happening of the following event:
MM DD YY

_____
(List/describe qualifying event.)

I authorize the release of my 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 Client

_____
Signature of Personal Representative *(Optional)*

___/___/___
Date of Signature

_____
Relationship to Patient (if Personal Representative)

6797 North High Street, Suite 100
Worthington, OH 43085