L.Freer Counselling RTC
Change begins with the first step

Authorization for use or Disclosure of Protected Health Information

Clients Name: _____

Date of Birth: _____ Date authorization initiated: _____

Authorization initiated by: _____
(client, provider or other)

Information to be released: _____

_____
(If this authorization is for Therapy Notes, you must not use it as an authorization for any other type of protected information)

Purpose of Disclosure: _____

_____

Person(s) authorized to make the disclosure: _____

Person(s) authorized to receive the disclosure: _____

This authorization will expire on _____/_____/_____ or upon the happening of the following event:

Authorization and Signature: I authorize the release of my confidential protected 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.
Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient.

Signature of Client: _____

Signature of personal representative: _____

Relationship to client if personal representative: _____

Date of signature: _____

Signature of Counsellor: _____