James L Moog MA LMFT MAC BCETS

Individual, Couple & Family Therapy

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information Release Purpose: □Medical □Psychotherapy □Legal □Financial □Spiritual

Client Information

Client Last Name___________________________First Name___________________________MI______
DOB_____/_____/______
Client Address____
Client Home Phone ____________________Cell/Work 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:_______________________________________
Address:____ Phone:_____________________
Date of Authorization: _____/_____/_______ Authorization valid for one year from signing or until:
____

Information to be Released
(Requests for release of psychotherapy notes cannot be combined with any other type of request.)

□ My entire medical health record
□ Only those portions pertaining to:____
□ Authorization for Psychotherapy notes ONLY

Authorization and Signature
I authorize the release of my confidential protected health information, as described in my directions above. I understand 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 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:____ Date:____________________________

If signed by a personal representative, please indicate your relationship to the client and/or the reason

and legal authority for signing: ____