Rev. Santa CanteWi Molina-Marshall – licsw, sep

1025 Connecticut Avenue NW, Suite 1000, 10th Floor,

Washington DC, 20036

www.hpbysanta.net . hpbysanta@gmail.com . 301537-6091

Authorization for Use or Disclosure of Protected Health Information

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: _____

Phone: _____

Address: _____

Date of Authorization: ___/___/_____

Authorization to expire on ___/___/_____ or upon the happening of the following event:

_____

_____

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

□ My entire mental health record

□ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)

□ 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:

_____

Purpose of Information Release:

□ Further mental health care □ Payment of insurance claim □ Legal investigation
□ Applying for insurance □ Vocational rehab, evaluation □ Disability determination
□ At the request of the individual □ Other (specify): _____

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 Date

If signed by a personal representative:

(a) Print your name: _____
(b) Indicate your relationship to the client and/or reason and legal authority for signing:
Patient is: □ minor □ incompetent □ disabled □ deceased
Legal authority: □ parent □ legal guardian □ representative of deceased