Expressive HeARTs THERAPY

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION FORM

Date: Therapist:

Patient Name: DOB: S.S.#

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my therapist, Jessica Klotz, LCPAT, to release/obtain:

This information should only be released to/obtained from:

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient or Authorized Representative:

Date: