**Authorization for Disclosure of Protected Health Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_**\_\_\_\_\_\_\_\_\_\_\_\_**\_

Authorization for Creative Bridges, LLC to:

[ ] Obtain from [ ] Disclose to [ ] Exchange with

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Client: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information:

[ ] Intake Evaluation [ ] Medications [ ] Virtual Gateway Documents

[ ] Treatment plans [ ] Discharge Summary [ ] Substance Use Treatment

[ ] Insurance Information [ ] Psychiatric Evaluation [ ] Other (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information is needed for the following purposes:

[ ] Provide ongoing treatment [ ] Coordinate treatment with other providers

[ ] Referral of client for services [ ] Obtain insurance or financial assistance

[ ] Other (Specifiy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the disclosure of my protected health information as described herein.

I understand that this authorization is voluntary and made to confirm my decision. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my decision. It is my understanding that I may revoke this consent at any time and that it will expire one year from the date it is signed or upon discharge from services.

 FAXED SIGNATURE AS GOOD AS ORIGINAL

Signature of client or authorized party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_