Authorization for Release of Information

Client Name:____ DOB: _______________________

Authorization for Stephanie Musial, ATR-BC, LMHC to obtain and exchange Information with:

Name: ____ Relation to Client: ___________

Address: ____

Telephone: ____

The information is needed for the following purposes:

[ ] Provide ongoing treatment [ ] Coordination of treatment with other providers

[ ] Referral of client for services

[ ] Other (Specifiy):____

I,___________________________(client/parent/guardian), 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 OR EMAILED FORM AS AN ATTACHMENT IS AS GOOD AS ORIGINAL

Signature of client or authorized party: __________________________________ Date: ______________