Authorization to Release/Obtain Protected Health Information

Client Information

Last Name: ___________________________ First Name: _______________________ Middle Initial: ______

DOB: ___/___/____ Age: ______ Social Security #: ____-___-____ Primary Phone #: ___________________

Home Address: ____

Email Address: ____

Recipient Information

I, _________________________, do hereby authorize ***Love & Laughter***, to (circle all applicable) release/obtain a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____________________________________

Phone: ________________________

Address: ____

Date Authorization is to begin (today's date): ___/___/______

Authorization to expire exactly one year after date of authorization.

Information to be Shared

- My entire mental health record
- Authorization for Psychotherapy Notes ONLY
- Mental Health Assessments
- Only those portions pertaining to: ____

Purpose of Information Release (circle all that apply)

Further mental health care	Payment of insurance claim	Legal investigation
Applying for insurance	Vocational rehab evaluation	Disability determination
Individual request	Job performance evaluation	

Other (specify): ___________________________________

418 S Broadway Suite 600
Tyler, Tx 75702
phone: (903)-705-7595
fax: (903)-298-0076

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

____ ________________

Witness 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:

Client is:

Minor Legally Disabled Deceased

Your Legal authority:

Parent/ Legal Guardian Representative of Deceased

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