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 The Light and The Lotus Counseling, LLC, 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.) Please initial where appropriate.

____ 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): _____

The Light and The Lotus Counseling, LLC
70 Church Street Flemington, NJ 08822
P: (908) 210-2904 | F: (908) 450-2094
thelightandthelotus.com

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 (Therapist) 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:

____ a minor
____ incompetent
____ disabled
____ deceased
____ Legal authority:
____ parent ____ legal guardian ____ representative of deceased

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