Authorization for Use or Disclosure of Protected Health Information

Client Name_____ DOB:___/___/____

I, _____, do hereby authorize Indy Therapy and Counseling LLC to

☐ RECEIVE
☐ RELEASE
☐ EXCHANGE

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
☐ 60 Days after termination of services

Information to be Released

☐ Evaluation, Diagnosis, Treatment Plan, Record Summary, and Coordination of Care
☐ All of the above except the following:

_____

☐ 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:

_____

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. I understand I may revoke this authorization at any time by contacting Indy Therapy and Counseling LLC and signing to revoke this release of information.

_____ _____

Signature Date

If signed by a personal representative:

Print your name: _____