Authorization for Disclosure of Protected Health Information

Client Last Name_____ First Name _____MI ___ DOB:___/___/____

Client Last Name_____ First Name _____MI ___ DOB:___/___/____

ClientAddress_____

Clients Phone: _____ Phone: _____

Clients Email Address: _____

Recipient/s Information

I/we, _____, authorize Intimacy Nature Therapy to release a weekly update of my progress and assessments of mental health information to the person or facility below:

Name of person/facility to receive medical information: _____
Phone: _____
Address: _____

Date of Authorization: ___/___/_____ Expiration upon termination of course completion.

Information to be Released:
❏ Assessments completed
❏ Course Progress
❏ Other: _____

Purpose of Information Release: Further mental health care,

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

_____ _____
Signature Date