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AUTHORIZATION for USE or DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ hereby authorize Karen Conklin-Johnson to use or disclose the protected health information (PHI) described below to the persons and for the purposes set forth below.

1. The person(s) or entity to receive the PHI:

Name: _____

Address: _____

Phone: _____

2. The type of information (PHI) that I authorize to be used or disclosed is (with dates if applicable):

_____

3. This PHI may be used or disclosed for the purpose of:

_____

4. Exceptions: _____

This authorization is in effect until: _____ or the end of the professional relationship between me and either named party above, at which time this authorization will expire. I understand that I may revoke the authorization, in writing, at any time, by notifying the releasing organization, but my revocation will not affect any releases made or other actions taken before the date of my revocation.

I understand that the designated information about me may be sent by mail or delivery service, transmitted by fax, electronic mail or other electronic file transfer mechanism, or exchanged verbally unless otherwise restricted by me. I agree that a photocopy or fax of this authorization shall be valid as the original.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal law.

I understand that I am not required to sign this authorization form and that my treatment will not be conditioned on whether I authorize the requested use or disclosure of PHI, except (1) if my treatment is related to research and the use or disclosure is for such research, or (2) my treatment is being provided to me solely for the purpose of creating information for disclosure to a third party, and the use or disclosure is for that third party.

I understand that I may see and copy the PHI to be released pursuant to this form if I so request, and that I will receive a copy of this after I sign it.

_____ _____ _____ _____
Signature of Client *Date* *Parent/Guardian/Personal Representative* *Date*

_____ _____ _____
Therapist or Witness Signature *Date* *Relationship/Authority of Personal Representative*

This authorization has been revoked by the client in writing effective _____
Date