SOLUTIONIST
COUNSELING SERVICES
WHERE PEOPLE DEVELOP HEALTHY SOLUTIONS FOR EVERYDAY LIVING

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_____ 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).*

- ☐ My entire mental health record
- ☐ Only those portions pertaining to: _____

(Specific provider name and/or dates of treatment)

9250 West Glades Road, Suite 209, Boca Raton Florida 33434
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- ☐ Authorization for Psychotherapy Notes Only (Important: If this authorization is for Psychotherapy notes, you must not use it as an authorization for any type of protected heath information).
- ☐ Other: _____

Purpose of Information Release:

- ☐ Further Mental Health Care
- ☐ Applying for Insurance
- ☐ At the Request of the Individual
- ☐ Payment of Insurance Claim
- ☐ Vocational, Rehab, Evaluation
- ☐ Legal Investigation
- ☐ Disability Determination
- ☐ Other (Specify): _____

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*

If signed by a personal representative:

a) Print your name: _____

b) Indicate you relationship to the client and/and or reason and legal authority for signing:
Patient is:
- ☐ Minor
- ☐ Incompetent
- ☐ Disabled
- ☐ Deceased

Legal Authority:
- ☐ Parent
- ☐ Legal Guardian
- ☐ Representative of Deceased

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