

Authorization to Release Information Form

I, _____(Patient Name) _____(Date of Birth)
Request and authorize **Barbara Davis, LCSW** to release my protected health information, as described below, to:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

Phone

Fax

I request that the information to be released consist of the following (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Reason for therapy/diagnosis | <input type="checkbox"/> General themes of treatment |
| <input type="checkbox"/> Attendance in treatment | <input type="checkbox"/> Billing information |
| <input type="checkbox"/> Progress and prognosis | <input type="checkbox"/> Summary of treatment |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Other (please explain below) |

I understand that if the authorized recipient is not a provider or health plan required to comply with federal privacy standards, the information pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may be disclosed by the recipient without obtaining further authorization.

Individual's Rights Relating to this Authorization:

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment and enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying the practice in writing of my revocation. I understand that my revocation will not be effective as to uses and/or disclosures of my health information that have been made prior to revocation.

Expiration Date: This authorization is valid until _____

I have had the opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient Representative's Signature if applicable Date