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) 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.) 2 Other:_____ ***

I,_____ understand that I am being notified that a supervisor, **Mr. Ricardo Pena, LCSW** will have access to my clinical and billing information in order to assist quality of clinical practice.

Purpose of Information Release: Further mental health care Payment of insurance claim Legal investigation Applying for insurance vocational rehab, evaluation disability determination at the request of the individual 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 your relationship to the client

Authorization for Use or Disclosure of Protected Health Information Client Information Client Last

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Client Home Phone: _____ Cell/Work Phone: _____

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_____Signature Date_____

If signed by a personal representative:

(a) Print your name: _____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is: minor incompetent disabled deceased

Legal authority: parent legal guardian representative of deceased