Authorization for Disclosure of Medical, Clinical and Educational Information

Re: _____ D.O.B.: _____

1. I am

_____ The Client

_____ The Person legally responsible for the client

2. I authorize Cynthia L. Steele to:

_____ Obtain information from

_____ Release information to

Facility/Name: _____

Address: _____

City, State, Zip: _____

Phone: ( ) _____

3. I authorize the disclosure of protected health information by

_____ oral _____ written _____ fax

4. Specific information to be released or obtained:

_____ all necessary medical information (e.g., medical history, lab tests, diagnosis)

_____ all information necessary for clinical treatment (e.g., psychiatric and psychological assessments/evaluations, treatment plans/summaries)

_____ other: _____

5. This information is necessary for ongoing medical, clinical and educational purposes including evaluations and treatment recommendations.

6. I understand that I have the right to revoke and/or restrict this authorization at any time provided that I submit a request in writing. Any revocation shall not apply to actions already taken in reliance on this authorization.

7. I understand the information disclosed as permitted by this authorization may be re-disclosed and may no longer be protected by the HIPAA Privacy Rule.

8. I authorize the periodic, ongoing disclosure of the above information until (fill in expiration date)

_____

or until (fill in an event that relates to the individual or purpose of the disclosure)

_____

Client/Parent/ Guardian Signature: _____ Date: _____

Client/Parent/Guardian Print Name: _____

Relationship to Client: _____

Witness: _____ Date: _____
Cynthia L. Steele, M.S. Ed., NCC