Lori Ben-Ezra, Ph. D. &
Associates Psychological Services, LLC

Authorization for Use or Disclosure of Protected Health Information

Client Name: _____

Date of Birth: _____

Date authorization initiated: _____

Authorization initiated by: _____

Name (client, provider, parent, other)

Information to be released:

_____ Authorization for Psychotherapy Notes ONLY

_____ Psychological Testing Results

_____ Other _____

Person/Agency Authorized to receive the Information:

_____

This authorization expires on: _____

I authorize the release of my/my child's confidential protected health information as described in the 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 with 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 health information.

Signature of Client, Parent or Legal Guardian

_____

Relationship to Client

_____

Date of Signature

_____