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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Client Information:
Name:_____ DOB: __/__/__ SSN:_____

Address: _____

I authorize Brittany Smith, LCSW to:

___Release Information to: ___Obtain Information from:

Name: _____

Address: _____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Description of information to be released (including dates):_____

_____

_____

Purpose of the disclosure of requested information:_____
_____

NOTICE OF CLIENT RIGHTS

I may refuse to sign this authorization. I may revoke this authorization at any time by providing written notice to the provider. The revocation will be effective from the date received and will not apply retroactively. I have a right to receive a copy of this authorization. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

This authorization automatically expires one year from the date of the signature, unless a different date is provided. (Insert date or event)_____

SIGNATURE

Signature:_____ Printed Name: _____

Date: _____ Relationship to client:_____

Witness:_____ Printed Name:_____