AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

CLIENT:

_____ _____
Name of Client Birth Date

_____
Street Address City, State Zip Code

AUTHORIZES:

Elizabeth LaBolt, LMFT #88920
P.O. Box 1395 Santa Monica, CA 90406
(708) 785-2692 liz@shorebeachtherapy.com

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO/FROM:

Contact Person:_____

Name of Organization:_____

Street Address:_____

City, State, Zip Code:_____

Phone Number:_____

INFORMATION TO BE RELEASED:

____ Assessment/Evaluation ____ Treatment
____ Diagnosis ____ Other (Specify) _____
____ Entire Record

PURPOSE OF DISCLOSURE: (Check applicable categories)
____ Client's Request ____Other(Specify)_____

I understand that PHI used or disclosed as a result of my signing this authorization may not be further used or disclosed by recipient unless such use of disclosure is specifically required or permitted by law. I understand that I have the right to receive a copy of this authorization.

EXPIRATION DATE: This authorization is valid until:_____

_____ _____
Client (or authorized representative) Date

_____ _____
Witness Date