AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

Address _____ Phone_____

I, _____, the client or authorized representative, authorize

Michelle D. Scheu, LSCSW to _____ release to and /or _____ obtain:

_____	Diagnosis/Prognosis	_____	Progress Notes/Report
_____	Treatment Plan	_____	Education Report
_____	Intake Summary/Report	_____	Legal Report
_____	Discharge Summary/Report	_____	Medical Report
_____	Psychological Evaluation Report	_____	Presence in Program
_____	Psychiatric Consultation Report	_____	Any information relevant to mental health.
_____	Substance Abuse Evaluation	_____	Other:

For the purpose of: _____ Evaluation/Treatment Planning _____ Case Coordination _____ Legal Proceedings

_____ Other _____

To/From _____

Address: _____

City, State, zip: _____

Phone: _____ Fax: _____

- I understand that under state and federal confidentiality provisions only information specified can be released to the specified person or agency.
- I understand that the information disclosed may be specifically protected by law.
- I understand that Michelle D. Scheu, LSCSW cannot ensure that the recipient will maintain confidentiality of the information I have agreed to release.
- This release must be revoked in writing and submitted to Michelle D. Scheu, LSCSW. Revocation can take place at any time except to the extent that action has already been taken. Unless revoked earlier this authorization expires:
  - _____ One year from the date of signature
  - _____ On the following date: _____
  - _____ Upon the following specific event: _____
- I understand that I have the right to a copy of this document if I so desire.
  - _____ I have received a copy of this document.
  - _____ I have waived my right to receive a copy of this document.

_____

Client or Authorized Representative Signature Date Relationship

_____

Witness Date

It is expressly understood that photocopies/fax of this authorization shall be as valid as the original.

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