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(ROI) Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____ First Name _____MI ___
DOB:___/___/____
Client Address:
_____
Client Home Phone: _____ Cell/Work Phone:
_____
Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____
Phone: _____
Address: _____

Date of Authorization: ___/___/_____
Authorization to expire on ___/___/_____ or upon the happening of the following event: _____
_____

Information to be Released (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.*)

- My entire mental health record
- Only those portions pertaining to:
  _____
  - (Specific provider name and/or dates of treatment)
- Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)
- Other:
  _____