Doreen Bridgman MS,CCC,SLP
641 Valley Road
Brielle, NJ 08730
doreen@thecognitivecoach.net
732-977-7381

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
_____My treatment plan and progress notes
_____Only those portions pertaining to: _____
_____ Other: _____
Purpose of Information Release:
____Treatment planning
____Other (specify): _____

Authorization and Signature
I authorize the release of my confidential protected health information, as described in my 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 to 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 protected health information.

_____
Signature_____ Date_____
(a) Print your name: _____
(b) Indicate your relationship to the client and/or reason and legal authority for signing:
Patient is: ___ minor ___parent ___ legal guardian