

**Authorization to Disclose Protected Health Information**

**Section 1: The Client**

<b>First Name</b>	<b>Middle Initial</b>	<b>Last Name</b>
<b>Address</b>	<b>Date of Birth</b>	<b>Phone</b>

I hereby authorize the disclosure of protected health information about the individual named above and declare that I am: \_\_\_ the individual named above OR \_\_\_ a personal representative because the patient is a minor, incapacitated or deceased.

**Section 2: Person/Agency Disclosing Information**

<b>Name</b> Cedars Counseling	<b>Address</b> 509 Crossway Ave, Murfreesboro, TN 37130	<b>Phone/ Fax</b> 615-896-9160 615-890-4555
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**Section 3: Recipient of Information**

<b>Name of Recipient</b>	<b>Address</b>	<b>Phone /Fax</b>
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**Section 4: Information That Will Be Disclosed**

- |                                                   |                                               |
|---------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Medical Records          | <input type="checkbox"/> Appointment Summary  |
| <input type="checkbox"/> Psychiatric Records      | <input type="checkbox"/> Initial Assessment   |
| <input type="checkbox"/> Alcohol and Drug Records | <input type="checkbox"/> Verbal Communication |
| <input type="checkbox"/> PCP Communication        | <input type="checkbox"/> Progress Notes       |
| <input type="checkbox"/> Emergency Contact        | <input type="checkbox"/> Discharge Summary    |
| <input type="checkbox"/> Other (specify) _____    |                                               |

**Section 5: The Purpose of the Disclosure**

- |                                                   |                                         |
|---------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Treatment and Evaluation | <input type="checkbox"/> Legal Purposes |
| <input type="checkbox"/> Continuity of Care       | <input type="checkbox"/> Employment     |
| <input type="checkbox"/> Other (specify) _____    |                                         |

**My signature indicates my willingness to have my information released to the above recipient.**

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Expires in 1 yr.**

**Signature :** \_\_\_\_\_ **Signed by:** \_\_\_ client \_\_\_ guardian \_\_\_ personal representative