Christopher Galton LPC

Authorization for Use or Disclosure of Protected Health Information

This form is for you requesting information to be sent to this provider or for this provider to send information to another person or organization.

Client Information

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

Sender / Recipient Information

I, _____, do hereby authorize
[ ] Christopher Galton LPC 106 Black River Road, Myrtle Beach, SC 29588 or
[ ] Name to send medical information: _____
Office/Organization: _____ Phone: _____
Address: _____

to release a copy of my mental health information to the person or office:
[ ] Christopher Galton LPC 106 Black River Road, Myrtle Beach, SC 29588 or
[ ] Name to send medical information: _____
Office/Organization: _____ Phone: _____
Address: _____

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

Information to be Released

[ ] My entire mental health record
[ ] Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)
[ ] Other: _____

Purpose of Information Release:

[ ] Further mental health care
[ ] Payment of insurance claim
[ ] Legal investigation
[ ] Applying for insurance
[ ] Vocational rehab, evaluation
[ ] Disability determination
[ ] At the request of the individual
[ ] Other (specify):
_____

_____ _____
Signature of Client **(Client's Parent/Guardian if under 18)** **Date**

_____
Witness