Christopher Galton, LPC

Authorization for release of Protected Health Information

USE THIS FORM ONLY:
FOR YOU TO REQUEST INFORMATION TO BE SENT TO THIS PROVIDER
OR INFORMATION TO BE SENT TO ANOTHER PERSON OR ORGANIZATION.

1. Client Name: _____ Date of Birth: _____

2. Information to be released:
[ ]Summary of Treatment to date [ ] Report [ ] Other: _____

3. Purpose of Disclosure:
[ ] Coordination of Care [} Other: _____

4. Persons authorized to make Discloure:

Name: _____
Address: _____

5. Persons authorized to receive Discloure:

Name: _____
Address: _____

6. Method of Disclosure
Written : _____ Verbal:_____ Electronic: _____

7. Today's date:_____Authorization to expire on: _____

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Signature of Patient:_____Date:_____
Signature of Personal Representative:_____