Authorization for Release of Personal Health Information

CLIENT INFORMATION

Client Name			
Address			
Phone Numbers	home	cell	work
SSN		DOB	

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PROVDIER INFORMATION

Individual Name		
Business Name		
Address		
Phone / Fax	PHONE	FAX

I authorize the release of private health information (PHI) regarding my treatment between Kate Hermanson, LPC, NCC and the mental health provider named above. I understand that:

- This authorization includes information related to alcohol and drug abuse, mental health treatment, except psychotherapy notes, and confidential HIV related information.
- HIV, alcohol or drug information, or HIV-related information will not be re-disclosed without my written consent
- I have a right to revoke this authorization to release information at any time by making a request in writing to Kate Hermanson, LPC, NCC. I may revoke this authorization except to the extent that action has already been taken.
- Signing this release is voluntary. My treatment will not be conditioned on my authorization of disclosure.
- This authorization does not authorize the above listed providers to discuss my private health information with anyone other than Kate Hermanson, LPC, NCC.

(Client/Parent Signature) (Date)