Authorization to Disclose Health Care Information

Client name: _____ Date of birth: _____

Previous name: _____

Please release health care information to:

Name and Organization: _____

Address: _____

City, State: _____Zip Code: _____Phone: _____

By signing this Authorization, I authorize _____to use or disclose the following health information (*check only one box*):

☐ All Health Information about me, including my clinical records, created or received by Eunice Lehmacher. LISW-CP. This information may include, if applicable:

- Information about mental health diagnosis or treatment including psychotherapy notes.
- Information about diagnosis or treatment for alcohol or drug abuse.
- Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).
- Information about diagnosis or treatment of Sexually Transmitted Disease(s).

☐ All Health Information about me as described in the preceding checkbox, *excluding* the following:

_____

☐ Specific Health Information *including only*:

_____

For the Purpose(s) of: _____

This authorization ends: (check only one box) ☐ in one (1) year

☐ when the following occurs: _____

Other Important Information

I may refuse to sign or cancel this Authorization at any time, in writing, as allowed by law. This will not affect any actions already taken by Eunice Lehmacher, LISW-CP in reliance upon my original request. There are three ways to cancel this Authorization:

1) Sign and date a revocation form. This form is available from Eunice Lehmacher; or
2) Write, sign and date a letter to Eunice Lehmacher to cancel the authorization; or
3) Sign, date and write "CANCEL" on this original form

My cancellation or refusal to sign this Authorization will not affect the commencement, continuation, or quality of Eunice Lehmacher's treatment of me. Once Eunice Lehmacher gives out the information, Eunice Lehmacher has no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

I hereby release Eunice Lehmacher from any and all legal liability that may arise from the use and disclosure of information as set forth in this Authorization.

_____ _____ _____

Signature of client or legally authorized representative Date Time

_____

Relationship if signed on behalf of the client by parent, legal guardian, personal representative, etc.

Revocation of Consent for Use and Disclosure of Health Care Information

Client name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I no longer want Eunice Lehmacher to use and disclose health care information about me for treatment, billing and payment, and health care operations.

I understand that:

- This request applies after I sign this document.
- Eunice Lehmacher may have already taken action based upon my earlier permission.
- Eunice Lehmacher is allowed, by law, to use and disclose my health care information to complete treatment, billing and payment, and health care operations already in progress. I agreed to this when I signed the "Consent for Use and Disclosure of Health Care Information".
- Eunice Lehmacher *is* allowed or required by law to release health care information without my permission under certain situations.
- Eunice Lehmacher does not have to provide any further health care services to me.

_____ _____

Client or legally authorized individual signature Date

_____

Relationship to client if signed on behalf of the patient by parent, legal guardian, personal representative, etc.