my
therapy place

Authorization for Use or Disclosure of Protected Health Information

Client Name: _____ DOB: _____

Guardian Name: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my health or mental health information to the person or facility below, as well as communication with collaterals as needed. Name of person/facility to receive my personal information:

my therapy place, PLLC
Phone: 336-383-1665
Address: 1400 Battleground Ave. Suite 209E, Greensboro, NC 27408

Date of Authorization: ___/___/_____ Authorization to expire on ___/___/_____ or upon discharge.

Information to be released: All communication, both written and verbal

Purpose: Service coordination

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____
Signature Date

_____
Print Name