Authorization for Release of Protected Health Information (PHI)

This form is used for:

- **marriage/relationship counseling**
- **including another adult in your sessions**
- **sharing information about your treatment** (with a PCP, psychiatrist, child's school counselor, etc.)

1. Persons authorized to share PHI:

By signing below, I, _____, authorize **Brenda Dolan, PLLC**
Patient/Guardian NAME

to disclose PHI to: _____
NAME and PHONE NUMBER of Person Receiving PHI

2. Purpose or Use of the Disclosure (e.g., family therapy, coordination with PCP):

_____

3. PHI being authorized to use or disclose (check one):

_____ All health information pertaining to my medical, mental, or physical condition and treatment received
_____ Only the following records, dates, or types of information:_____

4. Expiration of Authorization (check one):

_____ On date specified: _____
_____ In 90 days (for a one-time release of information)
_____ In 1 year from date authorization was given

5. Rights and Restrictions regarding this Authorization

I may refuse to sign. Signing this Authorization is not a condition for treatment, payment, enrollment, or eligibility of benefits. Substance abuse and HIV information will not be included with any other PHI that is released as federal law requires a specific authorization for disclosure of this information. The release of PHI and the release of psychotherapy notes requires separate authorization forms for each. One authorization form cannot be used for both. I have a right to receive a copy of this form. I may revoke this authorization at any time and the request must be in writing. I understand that, if the PHI authorized by this form is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be disclosed by the person authorized to receive the PHI.

Signature: _____Date: _____
(Patient or Guardian)

Therapist's Signature: _____Date: _____

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