# *Shainker Behavioral Therapy, LLC*

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## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the release of the following information obtained in the course of the treatment and diagnosis of _____, born_____.
(Name of Client) (DOB)

- ☐ Psychosocial Assessment
- ☐ History & Physical
- ☐ Psychiatric Evaluation
- ☐ Lab Reports
- ☐ Progress Notes
- ☐ Treatment Goals/Outcomes
- ☐ Last Three (3) Visits
- ☐ School Records
- ☐ Other (please specify)_____

This information may be released to:

(Please list the specific Healthcare Provider(s) that Shainker Behavioral Therapy may exchange **Protected Health Information** with)

Name:_____

Address:_____

Name:_____

Address:_____

This **Authorization to Disclose Protected Health Information** will automatically expire in one year on _____ unless you choose to revoke this authorization prior to the date listed above. You may revoke this authorization at any time by signing at the bottom of this authorization form.

The information that is disclosed under this authorization may be disclosed again by the person or organization that receives this information. The privacy of this information may not be protected under the federal privacy regulations.

You have the right to receive a copy of this authorization.

**I understand that by signing this form I am authorizing the above named person or agency to disclose the listed records that may include information about mental health, terminal and/or chronic illness, and substance abuse treatment.**

Patient Initials_____

Name of Client/Legal Guardian (please print):_X_____

Client/Legal Guardian Signature:__X_____

Client Social Security No.:__X_____ Date:_X_____

Relationship of Legal Guardian to Client:_____

Name of Witness (please print):_____

Witness Signature:_____ Date:_____

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**Please cancel the above authorization to release my Protected Health Information effective immediately.**

Client/Legal Guardian Signature:_____ Date:_____

Therapist Signature:_____Date:_____