*Ann-Marie Bowen, M.A., L.P.C.*
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# Authorization for Use and Disclosure of Protected Health Information

Name: _____ Date of Birth: _____
Address: _____
Social Security Number:_____ Contact Number(s):_____

I, the undersigned client or legal guardian, hereby authorize ___ verbal and/or ___written information to be released by Ann-Marie Bowen, LPC, to:

Name:_____ Phone:_____
Fax: _____ Address: _____
_____

Information to be released:
___ Initial Evaluation
___ Psychosocial Assessment
___ Progress Notes
___ Diagnosis
___ Treatment Planning
___ Discharge Summary

Release of Information is for the following purpose:_____

- I understand that the information released may include mental health, substance abuse, or HIV/AIDS information.
- I understand that this authorization is voluntary and that treatment by Ann-Marie Bowen cannot be conditioned on the signing of this authorization.
- I understand that there may be a charge, payable in advance, for the copying and conveyance of records released.
- I understand that this authorization may be withdrawn by me in writing at ay time. I cannot, however, take exception to actions that have taken place before I withdrew my consent.
- I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will not longer be protected. Ann-Marie Bowen is released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that the information being release is from records whose confidentiality is protected by state and federal law.

Client or Guardian Signature: _____ Date: _____
Witness: _____ Date: _____