Center for Cognitive Psychotherapy

Salvatore Ridente, LPC, LCADC, Ed.S
108 North Union Avenue Entrance A Suite 6 Cranford, NJ 07016

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. **Clients's name: _____**
   First Name Middle Name Last Name

2. **Date of Birth: ____/____/____**

3. **Date authorization initiated: ____/____/____**

4. **Authorization initiated by: _____**

5. **Information to be Released:**

   ☐ Authorization for Psychotherapy Note ONLY (**Important:** If this authorization is for Psychotherapy Notes, you must use it as an authorization for any other type of protected health insurance.)

   ☐ Other (describe information in details): _____

6. **Purpose of Disclosure:** The reason I am authorizing release is:

   ☐ My request

   ☐ Other (describe):_____

7. **Person(s) Authorized to Make this Disclosure:**

   _____

8. **Person(s) Authorized to receive the Disclosure:**

   _____

9. **This Authorization will expire on ___/___/____ or upon the happening of the following event:**

   _____

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 released 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 of the Patient: _____ Date _____

Signature of Personal Representative: _____

Relationship to Patient if Personal Representative: _____