Authorization to Exchange Information

This form authorizes me to exchange Protected Health Information from my clinical record or that of the child named below with the person or agency I designate.

I authorize _____ to exchange Protected Health Information with the following:

Name: _____

Phone Number and/or E-mail _____

Address: _____

This information is to be exchanged at my request. If there are any conditions to this

exchange, I will note them here: _____.

This authorization will expire on _____.

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 redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. I may revoke this authorization by signing and dating a handwritten note to that effect at any time.

Client Name (print): _____

Client Date of Birth: _____

Parent/Guardian Name (print): _____

Signature of Client or Parent/Guardian: _____