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RELEASE OF INFORMATION FORM

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

IDENTIFYING INFORMATION:

Client's Name: _____

Client's SSN: _____ Client's Date of Birth: _____/_____/_____

USE AND DISCLOSURE TO PERSON(S) OR ORGANIZATION(S):

By signing this form, I understand that I am authorizing James Drew, LPC, to use and/or disclose my PHI to the following person(s) or organization(s):

Name of Person(s) or Organization(s): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Facsimile Number: _____

PHI DESCRIPTION:

I specifically authorize the use and/or disclosure of the following PHI (*Please provide a detailed description of the particular information you are authorizing to be disclosed*):

_____

_____

_____

_____

_____

AUTHORIZATION AND SIGNATURE:

I understand the information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or Texas privacy law.

This Authorization is voluntary and I acknowledge that I may refuse to sign this Authorization form. I understand that I am not required to sign this Authorization form in exchange for receiving treatment from James Drew, LPC.

Signature of Client or Guardian: _____ Date: _____

Printed Name of Client: _____