AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I (print name)_____ Date of Birth: _____

I authorize the following using or disclosing party:

_____

to use or disclose the following health information.

- ☐ All of my health information
- ☐ My health information relating to the following treatment or condition:_____
- ☐ My health information covering the period from _____(date) to _____(date)
- ☐ Other: _____

The above party may disclose this health information to the following recipient:

_____

_____

Phone: _____ Fax: _____

Email: _____

This authorization ends: (Ends after one year if not specified)

Date:_____

CHELSEA KRAMER THERAPY — Release of Information

My Rights:
I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance.

In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re- disclosed by the recipient and is no longer protected.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____

Printed Name:_____

Date:_____

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