Authorization for Disclosure of PHI

I, the undersigned, hereby authorize Debra S. Unger, LCSW, ACSW to use or disclose PHI, or Protected Health Information, in the manner described in this authorization for the following patient:

Client name: ______________________________________ **Client DOB: ____________________**

I give permission for Debra S. Unger, LCSW, ACSW, to:

___Release PHI ___Obtain PHI ___Exchange PHI

PHI to be disclosed includes the following:

___Treatment summary ___Appointment Records ___Other (Specify):

____

The purpose of the disclosure is to:

___Coordinate services ___Other (specify):________________________________

I authorize disclosure of my PHI to the following clinicians/practitioners:

Name ____ Phone _____________________________

Address ____FAX _______________________________

Name ____ Phone _______________________________

Address ____ FAX _______________________________

I understand that my signature on this authorization form is voluntary and that not signing will not affect the ability to receive treatment at this practice. I understand that this authorization will expire in 180 days, unless revoked by me which I have the right to do at any time. I understand that any revocation will not apply to any PHI that has already been released in reliance to this authorization and to PHI created expressly for disclosure to the person/entity listed above. I understand that the PHI disclosed may be subject to re-disclosure by the person/entity receiving it and no longer protected by federal privacy regulations except in the case of drug/alcohol treatment, which must be clearly stamped "Do not re-disclose" and protected accordingly under 42 CFR part 2. I understand that any questions I have about the use or disclosure of this PHI can be directed to Debra S. Unger, LCSW, ACSW, at any time.

____ ____________________________

Client Signature Date

____ ____________________________

Legal Guardian Signature (for minors) Relationship to Client