STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

INFORMATION TO BE USED OR DISCLOSED:

The information covered by this authorization incudes but is not limited to:

Initial intake notes, treatment plans, progress notes

PERSON AUTHORIZED TO USE OR DISCOSE INFORMATION:

Michele A. Zimmer-Forster LCSW, LICSW, CSW-G

PERSON TO WHOM INFORMATION MAY BE DISCLOSED:

PCP: _____ Family member: _____

Specialist/Psychiatrist_____ Other: _____

EXPIRATION DATE OF AUTHORIZATION

This authorization is effective through _____ unless revoked or terminated, in writing, by the patient or the patient's personal representative.

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION:

You may revoke or terminate this authorization by submitting a written revocation to

Michele A Zimmer-Forester LCSW, LICSW, CSW-G

POTENTIAL FOR RE-DISCLOSURE

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____

Name of Patient (Print)

_____

Signature of Patient Date

_____

Signature of Patient's Personal Representative (as needed)

_____

Relationship of Patient's Representative to the Patient