Sam Stevens, LMFT

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize Sam Stevens, LMFT to use and disclose the specific protected health information described below

regarding: _____ Date of birth:_____

as is necessary to: __ release information to, and/or ___ receive information from:

_____
(person/organization)

_____
address city/ state (phone)

The information to be used or disclosed includes:	**YES**	**NO**
Social, medical or psychological reports.		
Medications used in treatment.		
Treatment goals and results.		
Information about drug and/or alcohol abuse or treatment		
Court or probation records		
Other:		
This information disclosure is necessary for the following purpose(s):	**YES**	**NO**
Diagnosis and evaluation.		
Treatment planning.		
To facilitate treatment.		
Other:		

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care professional or health care entity to disclose information to us: (1) We cannot deny our services or treatment to you if you refuse to make this signed authorization; (2) You have the right to inspect a copy of the protected health information to be used or disclosed; (3) You may refuse to sign this Authorization; and (4) We must provide you with a copy of the signed authorization. You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. **Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.**

By signing this Authorization, you may be directing us to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners by their ethical codes and under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

I have reviewed this Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and may no longer be protected.

_____ _____ _____
Client/patient (or) legal representative & legal representative's authority Date