Authorization for Use and/or Disclosure of Health Information

I understand that Martina Verba, LCSW, MPH will not condition treatment on my providing or refusing this authorization.

**I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Phone Number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**to disclose and receive information pertaining to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ from Martina Verba, LCSW, MPH.**

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature (below) unless a different date is specified \_\_\_\_\_\_.

Date

Revocation: This authorization is also subject to written revocation by the client at any time. The written revocation will be effective immediately upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify records: Please initial to specify type of information to be disclosed.

\_\_\_ Medical Records

\_\_\_ Psychiatric Records

\_\_\_ Drug/Alcohol Information

\_\_\_ Results of an HIV Test

\_\_\_ Other Health Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify

The recipient may use the health information authorized on this form for the following purpose: To aid in the psychotherapeutic treatment of the client (named above). A copy of this authorization is as valid as the original. Patient has a right to a copy of this authorization.

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent/Legal Guardian Date