



**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH**

Client Name: Jane Lee

DOB: 05/05/1985

I Jane Lee (client's name) authorize *Lisa Sciarani, LCSW/Your Path Forward* to  
 OBTAIN information from  DISCLOSE information to

Contact Name: John Armstrong	Organization/Relationship: Partner
Address: 1234 Therapy Lane	Telephone: 503-555-5555
City, State, Zip: Portland, OR 97214	Fax: N/A

Information to be used/disclosed consists of mental health care information:

- All records, or  Only the items checked below:
- Assessment or evaluation  Treatment Plan  Summary of Treatment
- Progress Notes  Coordination of care information  Other: For emergencies and safety planning only

The purpose for the disclosure/communication:

- Coordination of care  By request of the client  Other: In the event of an emergency or disruption in service

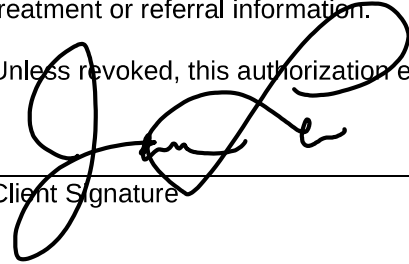
I understand that additional laws about mental health, alcohol/drug treatment, genetic testing, and HIV/AIDS may apply. I understand and agree that this information will be disclosed if I initial next to the type of PHI.

	Type of PHI
JL	Mental health information
JL	Alcohol/drug diagnoses, treatment, or referral information
	HIV/AIDS testing
	Genetic testing

**Client Acknowledgment and Authorization**

I understand that I am not required to sign this authorization. If I decline to sign this authorization, it will not prevent me from getting care. I understand that I may revoke this authorization in writing at any time, at which time any information described here may no longer be used or disclosed. Any information that has been used or disclosed prior to the revocation cannot be unshared. I understand that any information used or disclosed as a result of this authorization may be subject to re-disclosure. However, I also understand that federal and state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing, and drug/alcohol diagnoses, treatment or referral information.

Unless revoked, this authorization expires **60 days after the completion of treatment** or: \_\_\_\_\_

  
\_\_\_\_\_  
Client Signature

01/01/2023  
\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian/Personal Representative Signature Date

\_\_\_\_\_  
Parent/Legal Guardian/Personal Representative Name

Authority of representative:  Parent  Legal Guardian  Power of Attorney/Healthcare  Other: \_\_\_\_\_