Revive Therapeutics
Repair · Recover · Thrive
(860) 494-3800

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Information

Client Last Name: _____ First Name: _____ MI: _____

DOB: _____/_____/_____

Client Address:

_____

Client Home Phone: _____ Cell/Work Phone: _____
Client E-mail Address: _____

Recipient Information

I, _____do hereby authorize_____

To release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____

Phone: _____

Address: _____

Date of Authorization: _____/_____/_____

Authorization to expire on _____/_____/_____ or upon the happening of the following event:

_____

Information to be Released (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request*).

O My entire mental health record

O Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)

O Authorization for Psychotherapy Notes ONLY (**Important:** If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information).

O Other: _____

Purpose of Information Release:

Further mental health care	Payment of insurance claim	Legal investigation
Applying for insurance	Vocational rehab, evaluation	Disability determination
At the request of the individual	Other (specify): _____	

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____

Signature Date

If signed by a personal representative:

(a) Print your name: _____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is: minor incompetent disabled deceased

Legal authority: parent legal guardian representative of deceased