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Authorization for the Release or Disclosure of Protected Health Information

Authorization to Release Protected Medical Information

Patient

First and Last Name: _____

Date of Birth: _____

Street Address: _____ City, State Zip: _____

Phone: _____

Authorization

I hereby grant Kelly M. Chadwick, LCSW LLC authorization to:

☐ Release information **to** ☐ Release information **from** ☐ Discuss information **with**

Company/Provider/Person's Name: _____

Street Address: _____ City, State Zip: _____

Phone: _____ Fax: _____

Covering the period(s) of treatment from: _____ to _____ or ALL

Information Requested

☐ Records – Date(s) specified above

☐ Records DO NOT need to be sent

☐ Other: _____

For the Purposes of

☐ Coordination of care w/another provider

☐ Moving/Transferring Care

☐ Insurance/Disability/Legal

I understand if records are being requested, I must allow a two week processing period. I understand this authorization will expire in ONE YEAR unless otherwise indicated in writing. I understand I may revoke or edit this authorization at any time by providing written notification to Kelly M. Chadwick, LCSW LLC.

_____

Printed name of Patient or Authorized Representative

_____ _____

Signature of Patient or Authorized Representative Date