



AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Client Name: _____ DOB _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. Lynne Angela Santiago, LMHC is authorized to _____ make the disclosure to AND/OR _____ obtain information from:

Name: _____

Address/ph & fax number(s): _____

3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

- most recent history
- progress notes and/or treatment summary
- most recent discharge summary
- consultation reports from (please supply doctors' names): _____
- Psycho-social Assessment
- entire record
- Consultation by phone and/or email

other (please describe): _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse.

6. This information for which I'm authorizing disclosed or obtained will be used for the following purpose:

- my personal records
- sharing with other health care providers as needed for the continuity of my care.
- other (please describe): _____

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Lynne Santiago, MS, LMHC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire sixty days from termination of mental health services.

9. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure or obtainment of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative Date

Witness sign and date