

AUTHORIZATION TO RECEIVE OR DISCLOSE INFORMATION

I, _____ DOB _____
(Fill in your name) (Fill in your full birth date)

Authorize _____ to receive and/or disclose the
(Fill in name)

specific health and medical information described below.

___ Any applicable medical and or psychiatric records.

___ Only records during the period from _____ to _____.

___ Other _____

This information should be received from and/or disclosed to Rawan Martin LCSW-C for the purpose of (check all that apply):

___ Continuity of care

___ Coordination of care

___ Other

I have reviewed and understand the authorization. I also understand that the information received or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected under federal law.

Patient _____ Date _____

Witness _____ Date _____

Notice: I cannot make receipt of this signed Authorization condition of treatment. You may inspect a copy of the protected health information in question, you may refuse to sign this Authorization, and I must provide you with a copy of the Authorization if you request one. You have the right to revoke this Authorization at any time, provided that you do so in writing, except to the extent that I have already received or disclosed the information relying on this Authorization. Unless otherwise specified this Authorization will expire when transfer of care is complete.