Authorization to Disclose or Request Protected Health Information

1. I, _____ _____
Individual's Name (Please Print) *Date of Birth (mm/dd/yyyy)*

2. Of _____
Individual's Address

3. Authorize Bradford Wolf, LCSW to □ Exchange with □ Release to □ Receive from

4. The following Provider/Organization/Individual:

Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

5. The following information: □ Diagnosis □ Progress Notes □ Evaluation/Assessment □Medication(s) Prescribed
□ Psychological/Psychiatric Evaluation □ Social History □ Other _____
(Date or Event)

6. This authorization allows the indicated provider to share information described above for:
□ A single use or disclosure at the time of authorization
□ Ongoing use or disclosure during the time period specified:_____

7. The purpose of this disclosure is:
□ At the request of individual or personal representative □ Other *(specify purpose):* _____

8. I understand that:
- This authorization expires one year from the date of my signature, unless otherwise specified.
- Service providers using or disclosing information based on this authorization are to share the minimum necessary amount of the specified information to accomplish the purpose of the disclosure outlined above.
- The provision of treatment, payment, enrollment, or eligibility for benefits does not depend on whether I sign this authorization
- I may revoke (or cancel) this authorization at any time by submitting a written statement of revocation.
- The information to be released has been fully explained to me and this authorization is given of my own free will.
- I am entitled to a copy of this signed authorization.

9. Individual's Signature: _____ Date: _____

10. Other Signature: _____ Date: _____
Other Signee's Role**:** □ *Parent of Minor Child* □ *Guardian* □ *Legally Authorized Representative*

11. Provider/Clinician Signature: _____Date: _____

A copy of this document shall be as valid as the original.