Authorization for Use or Disclosure of Protected Health Information

I, _____ _____ hereby authorize Doreen Dubs, MA, LPC
Last name First name

to: ☐ release to ☐ receive from ☐ exchange with

_____ _____ _____
Name of Agency or Individual Address Phone

the following protected health information pertaining to the treatment of _____

- ☐ Intake summary, treatment plan, treatment progress summaries, and/or termination
- ☐ summary Progress notes dated:=
- ☐ Confirmation of and dates of service DSM-
- ☐ IV-TR diagnosis and/or medical diagnosis
- ☐ Other (List): _____

_____

This protected health information is being used or disclosed for the following purpose(s):

- ☐ Ongoing Medical Care OR
- ☐ Other (List): _____

_____

_____

The client has requested this information be used and disclosed but does not wish to specify the purpose.

In order for Doreen Dubs, MA, LPC to provide maximally beneficial service to my clients, it is often necessary for me to communicate with other people or agencies with whom you have or had contact. Your signature on this form gives Doreen Dubs, MA, LPC permission to contact the person(s) or agency named above and to share the information for which you have authorized release. Any other sharing of information gained during our contacts is expressly prohibited except in situations where disclosure is ethically or legally required.

This authorization shall be in force and effect for one year to the date of the client's signature on this form at which time this authorization to use or disclose this protected health information expires.

Date Authorization Expires (if different from one year to date of signature): _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

Doreen Dubs, MA, LPC
16523 Alcott Place
Broomfield, CO 80023

I understand that a revocation is not effective to the extent that my health care provider has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim or if my authorization was required for treatment provided by participating in a research study.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that if I refuse to sign this authorization I may not be eligible for, or receive research-related treatment or treatment that I have requested for the purpose of disclosure to others.

_____ _____
Signature of Client or Personal Representative Date

_____ _____
Print Name of Client or Personal Representative Description of Personal

Authority Representative's Authority and attach document evidencing authority, such as a Power of Attorney

_____ _____
Signature of Therapist Date