Authorization to Release Health Care Information

Ann Coco, LCSW

Client name: _____ Date of birth: _____

SSN: _____ Previous name: _____

Please release health care information to:

Name and Organization: _____

Address: _____

City, State: _____ Zip Code: _____

Release the following information:

_____ Health care information relating to the following treatment or condition:
_____

_____ Health care information for the date(s) below:

_____

_____ All health care information:

_____

_____ Other _____

This authorization ends: _____ in 90 Days; or

_____ when the following occurs (but not longer than 90 days):

_____

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form. This form is available from (physician or clinic); or
2) Write, sign and date a letter to the (physician or clinic) to cancel the authorization; or
3) Sign, date and write "CANCEL" on this original form

Once the (physician or clinic) gives out the information, the (physician or clinic) has no control over it. The recipient might redisclose it. Privacy laws may no longer protect it.

I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for:

HIV (AIDS virus),
Sexually transmitted diseases,
Psychiatric disorders/mental health, or
Drug and/or alcohol use.

_____ _____
Patient or legally authorized individual signature Date Time

_____Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

Revocation of Consent for Use and Disclosure of Health Care Information

Client name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I no longer want Ann Coco, LCSW to use and disclose health care information about me for treatment, billing and payment, and health care operations.

I understand that:

- This request applies after I sign this document.
- Ann Coco, LCSW may have already taken action based upon my earlier permission.
- Ann Coco, LCSW is allowed, by law, to use and disclose my health care information to complete treatment, billing and payment, and health care operations already in progress. I agreed to this when I signed the "Consent for Use and Disclosure of Health Care Information".
- Ann Coco, LCSW is allowed or required by law to release health care information without my permission under certain situations.
- Ann Coco, LCSW does not have to provide any further health care services to me.

_____ _____
Client or legally authorized individual signature Date

_____ _____
Relationship to client if signed on behalf of the patient by parent, legal guardian, personal representative, etc.