Authorization to Disclose Protected Health Information

Patient Name:	**Date of Birth:**
Address:	

I hereby authorize ***Emily Baugh, LPC*** to disclose the above-named individual health information as described below:

The type and amount of information to be disclosed is any and all psychological assessments, evaluations, clinical interview materials, reports, summaries of therapy and therapeutic treatment and/or recommendations.

The type and amount of information may include information about my mental health status. This information may be disclosed to and used by the following person or organization:

Person/Organization:

The disclosure and use if for the following purpose: ______________________________.
I understand I have a right to revoke this authorization at any time, and that if I choose to do so, I must revoke in writing, and present it to the health information management department or the provider of services. I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization, and such refusal may affect my ability to participate in certain treatments or programs.

By signing this authorization, I understand that any disclosure of information carries with it the potential for an unauthorized disclosure, and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization. A photostatic copy of this authorization shall serve in its stead.

Client 1 [Print name]:	Signature:	Date:
Client 2 [Print name]:	Signature:	Date:
Emily Baugh, MA LPC[Print name]:	Signature:	Date: