

**Dr. Carrie A. DeWolf**  
**Licensed Mental Health Counselor MH 13391**

**Authorization for Use or Disclosure of  
Protected Health Information**

**Client Information**

Client Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_

Client Address \_\_\_\_\_

Client Home Phone: \_\_\_\_\_

Cell/Work Phone: \_\_\_\_\_

Client Email Address: \_\_\_\_\_

**Recipient Information**

I, \_\_\_\_\_, do hereby authorize \_\_\_\_\_ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Authorization: \_\_\_/\_\_\_/\_\_\_

Authorization to expire on \_\_\_/\_\_\_/\_\_\_ or upon the happening of the following event: \_\_\_\_\_

**Information to be Released** (Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)

My entire mental health record

Only those portions pertaining to: \_\_\_\_\_  
(Specific provider name and/or dates of treatment)

Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

Other: \_\_\_\_\_

**Purpose of Information Release:**

- Further mental health care
- Applying for insurance
- At the request of the individual
- Payment of insurance claim
- Vocational rehab, evaluation
- Other (specify): \_\_\_\_\_
- Legal investigation
- Disability determination

**Authorization and Signature**

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

\_\_\_\_\_  
Signature Date

If signed by a personal representative:

- (a) Print your name: \_\_\_\_\_
- (b) Indicate your relationship to the client and/or reason and legal authority for signing:
  - Patient is:    minor            incompetent            disabled            deceased
  - Legal authority:  parent            legal guardian            representative of deceased