HealthySexualSolutions

Authorization Form

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize **Deegan Malone, Ed.S., LPC, JSOCC** to use or disclose the following protected health information from the records of the client listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Client's Name: _____

Date of Birth: _____

Address: _____

Information to be disclosed to:

_____

_____

_____

_____

Information to be released or requested:

_____ Results of Psychosexual Evaluation

_____ Verbal/Electronic Communication

_____ Other Documents Related to the Case (police reports, psychological evaluation)

_____ Other (describe information in detail):

_____

_____

_____

Purpose of Disclosure: The reason I am authorizing release is:

_____ My Request

_____ To Participate in the Preparation of a Psychosexual Evaluation

_____ Other (describe):

_____

_____

_____

I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

I acknowledge, and hereby consent to such, that the release information may contain alcohol and drug abuse, psychiatric, or genetic information.

This authorization expires one (1) year from the date it was signed by the patient or the patient's authorized representative. Photocopies of this document will suffice for the original copy.

Signature of Patient or Legal Representative:

_____ Date _____

Printed name of Patient:

_____