

AUTHORIZATION FOR USE OR DISCLOSURE  
OF PROTECTED HEALTH INFORMATION.

CLIENT'S NAME: \_\_\_\_\_  
FIRST NAME
MIDDLE NAME
LAST NAME

DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

DATE OF AUTHORIZATION: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

AUTHORIZATION INITIATED BY: Cypress Family Guidance Counseling  
NAME

INFORMATION TO BE RELEASED: Letter of introduction regarding care.

PURPOSE OF DISCLOSURE: To onset integrated behavioral health plan.

PERSON AUTHORIZED TO MAKE THIS DISCLOSURE: Cypress Family Guidance Counseling.

PERSON AUTHORIZED TO RECEIVE THIS DISCLOSURE: Primary care or attending physicians.

\_\_\_\_\_  
NAME
ADDRESS
PHONE

- This authorization will expire 1 year from \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ or upon verbal instruction.

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 OF CLIENT: \_\_\_\_\_

SIGNATURE OF PERSONAL REPRESENTATIVE: \_\_\_\_\_

REPRESENTATIVE'S RELATIONSHIP TO CLIENT: \_\_\_\_\_

DATE OF SIGNATURE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_