KELLEY GRAY, M.A.
LICENSED PROFESSIONAL COUNSELOR

Authorization for Use or Disclosure of Protected Health Information

Client Name: _____ Date: _____

Client Address: _____

Phone: _____ Date of Birth: _____

I, _____ hereby authorize Kelley Gray M.A., L.P.C. to release information to and obtain from

(Name of hospital, physician, clinic, school faculty,)

Entity Name:_____

Phone: _____ Fax: _____

Authorization initiated by: _____

Information to be Released:

Psychiatric Conditions/Treatment/Psychological Testing

Substance Abuse

Medical Information/Medications Prescribed

Treatment Summary/Recommendations/Consultation

Social History

Educational Information

Payment and/or Scheduling

This Authorization will expire on ___/___/___ or upon occurrence of the following event:

_____

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 the Patient: _____Date _____

Personal Representative: _____

Relationship of Representative: _____

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