Authorization for Use or Disclosure of Protected Health Information

Client Name: _____ Date of birth: _____

Client Address: _____

Client Phone: _____

I, _____, do hereby authorize Aaron Kurtz to share and/or

release a copy of my mental health information with _____.

Date of Authorization: _____ Authorization to expire on: _____

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.

Print name: _____

Signature: _____

Date: _____