Cindy Wall, LMHC

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Authorization for the Use and Disclosure of Protected Health Information

Federal law says that I cannot share your health information without your permission except in certain situations. If you sign this form, you are giving me permission to share the information you indicate below. If you decide later that you do not want me to share your information any more, you can revoke this authorization at any time in writing.

Name_____Date of Birth_____
Phone Number_____
Street Address_____
City_____State_____Zip_____

I give permission to Cindy Wall, LMHC to share the health information listed below with the following person or group. _____

Purpose for which the disclosure is authorized (example: treatment of my health condition or that of my child)_____

Describe the specific information that you want to be disclosed and the time period that the information covers. (example: psychological report, psychotherapy summary, education information)
Information: _____

Time Period for the information: From_____To_____

Enter the date you want this authorization to expire (if you do not enter a date, this authorization will expire in one year)_____

I understand that the above described person or group may re-disclose my information and that my information would no longer be protected by the federal privacy regulations. Therefore, I release Cindy Wall from all liability arising from the disclosure of my health information pursuant to this agreement.

I understand that I may inspect or request copies of any information disclosed by this authorization. I understand that I may revoke this authorization by notifying Cindy Wall, LMHC, knowing that previously disclosed information would not be subject to my revocation request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility for benefits.

Signature of Patient, Parent, or
Guardian_____Date_____