Authorization to use and/or disclose Protected Health Information

I hereby authorize Laya Seghi, LCSW to release/request information from my records to this person or organization :
Name/organization: _____

Information to be released:_____

_____

The information will be used/disclosed for the following purposes:
_____

_____

I understand that this Authorization will be valid and in effect unless it is revoked by me in writing or until it automatically expires 30 days after termination of treatment. If I choose to revoke this authorization, it will prevent any release of information after the date it is received, but can not change any actions taken before that date.
I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment. I also understand that I may inspect and have a copy of any written health information that is shared.
If the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

Signature of Client _____

Date _____

Printed Name _____

I acknowledge that I was offered a copy of this completed form.
I have discussed the issues above with the client. I have no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of Professional Date