DONNA BARTLETT, LCSW, LCAS, CMHt

AUTHORIZATION FORM

NAME___________________________________ DOB______________________

This form when completed and signed by you, authorizes the release of protected information from your clinical record to the person you designate.

I authorize the exchange of information between Donna Bartlett, LCSW, LCAS, CMHt and the following:

Primary Care or Referring Physician
Name______________________________________ Office Phone_________________________________
Address____
City____ State___________________ Zip______________________

Other provider
Name____ Office Phone_________________________________
Address____
City____ State___________________ Zip______________________

Other provider
Name____ Office Phone_________________________________
Address____
City___________________________ State___________________ Zip______________________________________

INFORMATION TO BE RELEASED: ____
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This authorization is only for the limited purpose of obtaining from or releasing information to, and discussing my case with these individuals or companies for the specific purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information.

I am requesting this information exchange for the purpose of ____

This authorization will remain in effect for two years unless you designate a different time period below. You may revoke this authorization at any time by giving me written notice.

Expiration if different from above:____

This Authorization is fully understood and is voluntarily made on my part.

____ OR _______________________________________

Patients Signature | Parent or Legal Representative's Signature

____ _______________________________________

Date of Signature | Relationship if not parent

Witness____

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Forms/auth