# Authorization for Use or Disclosure of Protected Client Information

**Client Information**

Client Last Name_____ First Name _____MI ___
DOB:___/___/____
Client Address
_____
Client Home Phone: _____ Cell/Work Phone: _____
Client Email Address: _____

**Recipient Information**

I, _____, do hereby authorize Dr. Linda Levine Silverman to release a copy of my information to the person or facility below:

Name of person/facility to receive information: _____
Phone: _____
Address:
_____

Date of Authorization: ___/___/_____
Authorization to expire on ___/___/_____ or upon the happening of the following event:
_____

**Information to be Released**

____ My entire record

____ Only those portions pertaining to:
_____

____ Other:
_____

**Purpose of Information Release:**

___ Further mental health care
___ Continuity of services with referral source
___ At the request of the individual
___ Other (specify)

**Authorization and Signature**

I authorize the release of my confidential protected 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 information.

_____ _____

Signature Date