AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

CLIENT:

_____ _____
Name of Client Birth Date

_____
Street Address City State Zip Code

AUTHORIZES:

Andrew Lawrence Lande, M.A., LMFT 106800
818.290.8390 andrew@andrewlandemft.com

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO/FROM:
Contact Person:_____
Name of Organization:_____
Street Address:_____
City, State, Zip Code:_____
Phone Number:_____

INFORMATION TO BE RELEASED:
☐ Assessment/Evaluation ☐ Treatment ☐ Diagnosis ☐ Other(Specify)_____
☐ Entire Record

PURPOSE OF DISCLOSURE: (Check applicable categories)
☐ Client's Request ☐ Other(Specify)_____

I understand that PHI used or disclosed as a result of my signing this authorization may not be further used or disclosed by recipient unless such use of disclosure is specifically required or permitted by law. I understand that I have the right to receive a copy of this authorization.

EXPIRATION DATE: This authorization is valid until:_____

_____ _____
Client (or authorized representative) Date

_____ _____
Witness Date