**AUTHORIZATION FOR USE OR DISCLOSURE OF**

**PROTECTED HEALTH INFORMATION**

**DIANE CAROLAN-STEGMAN PSYCHOTHERAPY LLC Phone: 913-353-4302**

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**CLIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_**

**I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby authorize Diane Carolan-Stegman, LSCSW,**

**to release or disclose protected health information to the person or facility below:**

**Name of person/facility to receive medical information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Purpose of information release:**

 **\_\_\_\_\_ Coordination of care \_\_\_\_\_\_\_\_ Disability determination**

 **\_\_\_\_\_ Payment of insurance claim Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Information to be released:**

**\_\_\_\_\_\_\_ Entire medical record \_\_\_\_\_\_\_\_ Record of attendance to sessions**

**\_\_\_\_\_\_\_ Treatment Summary \_\_\_\_\_\_\_ Verbal exchange only**

**Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This authorization will expire six months from date of signature unless otherwise volunteered and agreed to by client.**

**I authorize the above initialed disclosure of medical information. I understand that this authorization is voluntary and the use/disclosure is to be made to conform to my directions.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature**