# Authorization for Use and Disclosure of Protected Health Information (PHI)

I, ______________________________________________________________________________

Print Name                                                                 Date of Birth

hereby authorize Michelle Lodato, MSW, LCSW to: (check all that apply)

Request/Obtain ☐   and/or   Release/Disclose ☐

my information (PHI) as described below to:

Person/Organization Authorized: ______________________________________________

Address ______________________________________ Phone Number ( ) -

I authorize the following information to be released:
(Client should initial each item to be disclosed)

| | |
|---|---|
| ☐ Admissions/Treatment/Discharge Summary | ☐ Substance Use/Abuse |
| ☐ Social History | ☐ Alcohol Use/Abuse |
| ☐ Psychiatric Evaluations | ☐ Treatment Plans |
| ☐ Medications | ☐ Program Dates: Start - End |
| ☐ Demographics | ☐ Diagnosis |
| ☐ Presence/Participation in Treatment | ☐ Other ______________ |

The purpose of this Authorization is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: ______________________

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Michelle Lodato, LCSW at 206 Main Street, Suite22, Millburn, NJ 07041. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

The expiration date for this Authorization is one year from date of signature, unless sooner revoked.

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically. Information disclosed to Michelle Lodato, LCSW, as a result of this Authorization is not re-disclosed to third parties. However, information disclosed by Michelle Lodato, LCSW may be subject to re-disclosure by the recipient and may no longer be protected by Michelle Lodato's policies on disclosure or Federal regulations on disclosure.

Signature of Client ______________________________________________ Date __________

Signature of Parent/Guardian ______________________________________ Date __________

Signature of Legal Representative __________________________________ Date __________

Legal Rep must describe their authority to act on client's behalf.