

Erik Bohlin, M.A. LMHC

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**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
FOR PURPOSES REQUESTED BY PATIENT / REPRESENTATIVE**

Type of Information to be Disclosed:

I hereby authorize **Erik Bohlin, M.A.** to use and/or disclose the following protected health information:

Records - outside health provider

Telephone Consult of current issues

Purpose: Patient Request

Recipient of Protected Health Information:

Addressee(s) Institutional Group or other Affiliation

Business Phone Address City State Zip

Deliver By

Mail Fax () _____ Phone () _____ E-Mail _____

Revocation / Redisclosure:

It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already occurred based on prior authorization, and/or including provision of health care services requiring disclosure to effectuate payment. Unauthorized redisclosure by recipient is a potential risk.

Duration:

If not previously revoked, this authorization will expire: _____
(must specify date, event, or condition)

Specific Limitation: Except as to third-party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from date of last signature.

Signature:

This Authorization covers protected health information pertaining to _____.

Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the Date of that signature (initial or renewal). I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment or eligibility for benefits.

Initial Signature (Patient/Parent/Guardian/Other legal representative for health care decisions) _____ Date _____

Witness _____ Date _____

Renewal Signature _____ Date _____