Pediatric Adolescence
Professional Psychology

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Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____First Name_____MI ___
DOB:_/__/___
Client Address

_Cell/Work Phone:_____

Client Email Address: _____

Recipient Information

I,_____, do hereby authorize Dr. Stern the release of my confidential protected health information. 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 health information. to release a copy of my mental health information to the person or facility below.

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

_____ _____
Signature Date