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Authorization to Release Confidential Personal Health Information (PHI)

I, _____, hereby authorize Marjorie Milstein, LCSW to release either through written documentation or verbal exchange confidential health information regarding my condition, treatment, and status with:

_____
Health professional or institution

_____ _____
Address Phone

I understand that this PHI will be used in the service of my treatment.

I understand that I may revoke or modify this authorization in writing at any time, but unless otherwise revoked this authorization will automatically expire on _____.

I also understand that I did not have to sign this authorization, that if the person or entity receiving my PHI is not a healthcare provider or health plan covered by federal privacy regulations, the information released may be re-disclosed and no longer protected by those regulations.

I herby release Marjorie Milstein, LCSW from any legal liability that may arise from my authorizing her to release this confidential information. I also understand that I have a right to receive a copy of this authorization. I affirm that everything in this form that was not clear has been explained and I believe I now understand all of it.

_____ OR _____ _____
Signature of patient Personal representative and authority of representative Date

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I, _____, hereby authorize: _____
Health professional or institution

_____ _____
Address Phone

to release either through written documentation or verbal exchange confidential health information regarding my condition, treatment, and status with Marjorie Milstein, LCSW.

_____ OR _____ _____
Signature of patient Personal representative and authority of representative Date