Authorization to Obtain & Disclose Protected Health Information

Client's Name : _____ **DOB** : _____

I authorize Dr. Nick Weiss to obtain & disclose my protected health information from/to the following person/entity:

Name : _____

Address : _____ **Phone** : _____

_____ **Fax** : _____

_____

Limits on information to be obtained/disclosed:

_____

_____

_____

_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health records may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I may revoke this authorization at any time in the future, and that I have the right to refuse to sign this authorization. By singing this form, I have read and agree to the terms of this form.

Client Signature : _____ Date : _____

This authorization expires at the conclusion of treatment, 1 year from the above date, or upon client request, whichever happens first.

From the practice of Nick Weiss, M.D.
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