MELANIE CHUNG-SHERMAN, LCSW PLLC.
Empathy. Encouragement. Empowerment.

AUTHORIZATION TO RELEASE INFORMATION

Patient's Full Name | **Other Name (if applicable)**

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   His/her/its Name

   Address

   City, State Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

_____

_____

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, DO NOT DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____ .
7. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me in writing to Melanie Chung-Sherman, LCSW, PLLC.: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. The cost is $25 per copy/page. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signatory.

Official Use Only		
_____	_____	_____
Received	**Processed By**	**Log #**