Authorization for Request of Information

Name: ____
(Last) (First) (Middle Initial)
Date of Birth: _ _/_ _/_ _ _ _
Date Authorization initiated: _ _/_ _/_ _ _ _
Authorization initiated by:
____
Name (client, provider, or other)

Information to be requested:
(Describe information in detail): ____

Please request health, education, etc. information from:
Name/Program: ____
Address: ____
City, State, Zip Code ____
Phone (if known): _____________________________ Fax: ____________________

Please send information to the attention of ____
At **the following address/Fax:** ____
____
____

This authorization will expire on __/__/____ or upon the happening of the following event:

I authorize my information (which may include confidential protected health information, educational information, or legal information) requested as described in my directions above to be released to Anna Davenport, LMFT at Magnolia Counseling, LLC. I understand that this authorization is voluntary, that the information disclosed may be 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 redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Client: ____Date________________

Signature of Personal Representative: ________________________________Date_________________

Relationship to Client if Personal Representative: ____

Witness Signature: ____ Date ________________