Authorization for Release of Protected Health Information

MARIE CARTER & ASSOCIATES
Pastoral Counseling Services

Client:
_____

Person authorizing the release of information:
_____

Person authorized to receive the information:
_____

Information to be released:
_____

_____
_____

_____
_____

_____
_____

Information to be released is to be used for:
_____

_____
_____

_____
_____

This authorization will expire on the following date, event or condition, if not revoked before that time. I understand this Authorization may be revoked at any time except to the extent that action has already been taken in reliance on this document. _____

_____
_____

_____
_____

_____ _____

Signature Date

If this authorization is being signed on behalf of another, it is because: _____

_____

_____