



**AUTHORIZATION FORM**  
**(PLEASE CHECK ALL APPLICABLE BOXES)**  
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1. I am completing this form to allow the use and sharing of protected health information about:

\_\_\_\_\_ (Client's Name)

\_\_\_\_\_ (Date of Birth)

2. I authorize VERONICA LICHTENSTEIN LMHC, the administrative staff, and VERONICA LICHTENSTEIN

To obtain  or  disclose the following information:

Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.

**Billing Information**

Other \_\_\_\_\_

To the following person or organization:

From the following person or organization:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Client's relationship to this person: \_\_\_\_\_



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3. This release shall permit my therapist VERONICA LICHTENSTEIN LMHC to speak directly to the party or organization named in Section 2 concerning my care as provided in the same said section.
4. I understand and agree that this Authorization will be valid and in effect until \_\_\_ / \_\_\_ / \_\_\_ (enter a date upon which this Authorization expires.) I understand that after that date no more of this information can be used or released to the person or organization unless I sign a new Authorization.
5. I understand that I can revoke or cancel this Authorization at any time by sending a letter to VERONICA LICHTENSTEIN. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
6. I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
7. I understand that information used or disclosed pursuant to the Authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

\_\_\_\_\_  
Signature of Client or his/her Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Client or Personal Representative

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Description of Personal Representative's Authority