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Nurturing
growth for positive change

Authorization for Use or Disclosure of Protected Health Information

Client Information
Client Last Name_____ First Name _____MI ___ DOB:___/___/____
Client Address_____
Client Home Phone: _____ Cell/Work Phone: _____

I (Full name of client) _____, do hereby authorize Dr. Alyce Cisine, LLC, to
□ RELEASE TO □ RECEIVE FROM □ EXCHANGE WITH
(Name of Agency/Individual) _____ Phone: _____
Address: _____

Date of Authorization: ___/___/_____ Authorization to expire on ___/___/_____ or upon the happening of the following event: _____ (or upon 180 days from date of signing if no date/event/condition is specified)

Information to be Released
□ My entire mental health record □ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment) □ Other: _____

Purpose of Information Release:
□ Further mental health care □ Payment of insurance claim □ Legal investigation □ Applying for insurance
□ Vocational rehab, evaluation □ Disability determination □ At the request of the individual
□ Other: _____

Authorization and Signature
I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is 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 re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. This authorization extends to all or any part of the records/information designated above which may include diagnosis and/or treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS, and may include information from sources other than Dr. Alyce Cisine, LLC.

_____ Signature _____ Date

If signed by a personal representative, please print your name: _____

Indicate your relationship to the client and/or reason and legal authority for signing: Patient is: □ minor
□ incompetent □ disabled □deceased □ parent □ legal guardian □ representative of deceased