AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I ________________________________, date of birth ________________ hereby voluntarily authorize the disclosure of information from my health record. This information is to be disclosed by Brenda Sommer Therapy & Consulting, LLC located at 1801 Woodfield Drive Suite 207 Savoy, Illinois 61874. Brenda Sommer Therapy & Consulting, LLC can be contacted at 309/531-8945.

Protected Health Information is to be released/provided to:

Name of person/organization/entity/facility: ____

Address, City, State, Zip: ____

Phone Number: __________________________ Fax Number: _________________________

The purpose or need for this disclosure is: (circle all that apply)

- Insurance billing
- Employment reasons
- Further medical care
- School/educational
- Legal
- Other: __________________________

The information to be disclosed from my health record: (circle all that apply)

- Billing records
- Treatment plans
- Treatment attendance
- Fee payment history
- Diagnosis
- Progress notes by provider
- Entire record
- Only information related to: _________________________

I understand that I may revoke this authorization in writing submitted at any time to Brenda Sommer Therapy & Consulting, LLC, except to the extent that action has been taking in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature. I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule. I understand that I have the right to receive a copy of this authorization upon request. If I have any questions about the disclosure of my health information, I may contact Brenda Sommer, MA, LCPC, 309/531-8945.

____ ____________________
Signature of client or personal representative Date

____ ____________________
Signature of Witness Date