TED GREENBLATT COUNSELING
AUTHORIZATION FORM

Authorization to Use and Disclose Protected Health Information

1. I _____ (print name) am completing this form to allow the use and sharing of protected health information about myself.

   Date of Birth _____

2. I authorize psychotherapist, Ted Greenblatt to release the following information (Please check all that apply):

   - ❑ Presence in treatment
   - ❑ Dates of sessions
   - ❑ Topic of sessions
   - ❑ Clinical Impressions
   - ❑ Treatment Recommendations
   - ❑ Other: Please specify

     _____

3. To this person or organization (include name, address and Phone):

   _____

   _____

   _____

   _____

4. I understand and agree that this Authorization will be valid and in effect until (enter specified date) _____or the date upon which this Authorization expires (90 days). I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

5. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and or to the individual therapist who is to supply this information. 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 I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the professional or facility listed at number 2 above, nor will it affect my eligibility for benefits.

7. I understand that I may inspect and have a copy of the health information described in this document.

8. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

9. I understand that this professional or facility will not receive compensation for the disclosure of my health information.

10. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it. (Clients 13 and older should sign their own Authorization for Release).

    _____
    Signature of client or parent or guardian

    _____
    Printed name of client or parent or guardian

    _____
    Relationship to the client

    Date _____

11. I acknowledge that I received a copy of this completed form.

12. I, a mental health professional, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

    _____
    Signature of professional

    _____
    Printed name of professional

    Date: _____