Salt Lake Relationship Therapy
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AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF CONFIDENTIAL INFORMATION

By completing this form, you are authorizing the use and/or disclosure of individually identifiable health information, as outlined below, concerning the privacy of such information. All information requested in this form must be provided for this Authorization to be valid.

Client Name: _____ Date of Birth: _____

My therapist _____ is authorized to (*check all that apply*):

☐ Release or disclose records and/or information.

☐ Obtain or use records and/or information.

☐ Mutually discuss and exchange information.

This information should only be released to:

_____

(Name or function of person or organizations with whom the information is to be shared)

Specific Information to be Released/Obtained *(Please select only one)***:**

☐ All health/mental health information including diagnosis and treatment.

☐ Only the following records or types of information:

_____

Please specify if any information is to be excluded:

_____

This disclosure of information authorized by the client is required for the following purpose(s):

_____

This authorization shall become effective immediately and will expire in one year.

Please Note: *If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.*

Your Rights: *You may refuse to sign this Authorization. You may revoke this Authorization at any time by delivering your revocation in writing to your therapist. Your revocation will be effective when your therapist receives it; however, this revocation will not extend to information that was already obtained or released (used or disclosed) prior to the revocation. You have the right to receive a copy of this Authorization. You may inspect or obtain a copy of your mental health information, within the limits of Utah and federal laws.*

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Signature of Client/Parent/Guardian Date Relationship to the Client

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To Revoke Authorization

Authorization Revoked: _____

Signature of Client/Parent/Guardian Date