ICTherapy Works
545 N Woodlawn Blvd. Wichita, KS 67208
316-260-6889

Authorization for Use and/or Disclosure of Protected Health Information

Client's name ____________ DOB ____________ SS # ____________

I authorize my therapist, ______________________
Therapist's name

(Select all that apply)

- ☐ To exchange information with:

  Name: ____________ Phone #: ____________

- ☐ To give information to:

  Address: ______________________

- ☐ To receive information from:

  Name: ____________ Fax #: ____________

The information authorized to be disclosed, received or exchanged:
(Select all that apply)

- ☐ Psychiatric treatment records-psychiatric assessment, psychological testing report, discharge summary
- ☐ Psychotherapy treatment summary
- ☐ Attendance
- ☐ Written and verbal communication or consultation
- ☐ Medication
- ☐ Other: ______________________

I authorize this information to be used for the following purposes:
(Select all that apply)

- ☐ At the request of patient
- ☐ For treatment planning
- ☐ Collaboration of treatment
- ☐ Other: ______________________________

This authorization will expire:

- ☐ Upon termination of treatment
- ☐ Other date: ______________________________

In signing this authorization, I understand and acknowledge the following:
(Initial the spaces provided)

_______ I understand that this authorization is voluntary and that I may refuse to sign it

_______ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment

_______ I understand that I may revoke this authorization at any time by notifying my therapist in writing of my intent, except to the extent that action has been taken on this authorization

_______ I understand that once the disclosures have been made, the information disclosed may be subject to re-disclosure by any recipient and is no longer protected by federal privacy laws

I, the undersigned, do hereby swear that I am the above-mentioned patient or a legal representative of the above-mentioned patient. I have read and understand the above information.

______________________________ ______________
Signature of client or legal representative Date

____
Printed name of client or legal representative

____
Description of legal representative’s relationship to client