Marianne Tomlinson Therapy, LLC
1605 W. Wilson St., Suite 111
Batavia, IL 60510

## AUTHORIZATION FOR RELEASE OF INFORMATION

1. Client's Name _____
   First Name Middle Name Last Name
   Date of Birth:_____/_____/_____

2. Date authorization initiated: _____/_____/_____

3. Authorization initiated by: _____
   Name (Client, Provider or Other)

4. Information to be Released:
   _____ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)
   _____Other (Describe information in detail): _____

5. Purpose of disclosure: The reason I am authorizing release is:
   _____ My Request
   _____Other (Describe): _____

6. **Person(s) Authorized to Make the Disclosure (Include name, address, and phone number):**

   _____

7. **Person(s) Authorized to Receive the Disclosure (Include name, address, and phone number):**

   _____

8. **This Authorization will expire on _____/_____/_____ or upon the happening of the following event:**

   _____

**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 redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

**Signature of the Client: _____**

**Signature of Personal Representative: _____**

**Relationship to Patient if Personal Representative: _____**

**Date of Signature: _____**

**Signature of Witness: _____ Date: _____**