Easttown Pscyhotherapy, L.L.C.

Authorization for Exchange of Protected Health Information (PHI)

Client Name:_____DOB:_____

Client Address:_____Phone:_____

I Authorize: To Disclose or Exchange Information To:

Easttown Psychotherapy, LLC
400 E. Wisconsin Ave., Suite 220A
Milwaukee, WI 53202

Phone: (414) 793-4396 Fax: (414) 249-3111 Phone: Fax:

The purpose of this request is for:

The type and amount of information to be used or disclosed is for the following dates.

From: To:

Information to be disclosed is the following:

( ) Psychotherapy notes ( )Treatment Plan ( ) Recommendations

( ) Diagnosis and Prognosis ( ) Verbal exchange of information

( ) Other:

( ) Miscellaneous Reports

I understand that I have a right to rescind this authorization at any time. I understand that if I rescind this authorization I must do so in writing and present it to Easttown Psychotherapy, L.L.C. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following stated date:
If a date is not identified this authorization will expire 12 months from date signed.

I understand that authorizing the disclosure of this health information is voluntary and I need not sign this form in order to assure treatment. I understand that I may inspect or receive a copy of the information to be disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and information may not be protected by federal privacy standards. If I have any questions about disclosure of my health information I can contact Easttown Psychotherapy, L.L.C. at (414) 793-4396.

Client Signature:_____Date:_____

Parent/ Legal Guardian:_____Date:_____

Agency Witness:_____Date:_____