AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
PURSUANT TO 45 C F R § 164.508(c)(2)(i-iii)

I hereby authorize _____
to use or disclose the following protected health information, including computer records and those records disclosed from other medical persons/institutions, and any information regarding substance or alcohol abuse, psychiatric treatment, psychological treatment, sexually transmitted diseases, HIV (AIDS) testing or treatment, genetics, social services notes, or other sensitive information, from the medical record of the patient listed below, as well as invoices and itemizations of all services. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient Name_____ DOB: _____

Address_____

Information to be disclosed to: **Lillian Lennox, LMHC**
PO Box 594
Lenox MA 01240
413 446 9541

Disclosed the following information for treatment dates: _____

Complete Records	Abstract, to include:	X-ray Films
Face Sheet	Discharge Summary	Pathology Slides
History & Physical	Admission Notes	Clinical Progress Notes
Consultations	Reports of Medical	Autopsy Reports
Outpatient Test Results	Surgical Procedure	Correspondence
Physician Progress Notes	Pathology Reports	Billing Records
Emergency Records	X-Ray Reports	Computer Records
Other____		

The above information is disclosed for the following purposes: at the request of the individual.

Medical Legal Insurance Personal Other_____

This authorization also permits you to discuss any issues related to my condition, care, diagnosis, treatment or prognosis with the entity listed above. I understand that I may revoke this authorization at any time by requesting such of the above referenced hospital/physician/therapy practice in writing, unless action had already been taken in reliance upon it, or during a contestability period under applicable law, and that the covered entity may not condition treatment or payment upon my refusal to sign this authorization. I give my consent that a photocopy of this authorization shall be effective as an original.

_____ _____
Signature of Patient or Legal Representative Date
See 45 CFR § 164.508(c)(1)(vi)

_____ _____
Printed Name of Patient or Legal Representative Relationship to Patient
See 45 CFR § 164.508(c)(1)(iv)

This authorization expires one year from date of signature