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Medical Release Form

The privacy law, Health Insurance Portability & Accountability Act (HIPAA), protects my individually identifiable health information. The privacy law requires me to sign an authorization in order for researchers to be able to use or disclose my protected health information for psychotherapy purposes only.

1. I authorize the following person(s) and/or organizations(s) to disclose my protected health information (as specified below):
   Name:_____
   Organization(s):_____
   Address:_____

2. I authorize the following person(s) and/or organizations(s) to receive my protected health information (as specified above):
   Name:_____
   Organization(s):_____
   Address:_____

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____

Client/Guardian Signature Date

_____

Witness Signature Date