anna d. grimm MA, LMFT, CDVC

**Connected Marriage And Family Therapy**
**Authorization for Release of Information**

Client Name:_____

I hereby authorize Connected Marriage and Family Therapy to request, disclose, or use my Protected Health Information (PHI) as described below

| Persons/Organizations authorized to provide/receive information: | Specific description of information: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Purpose of the disclosure:

_____
_____

I understand that I have the right to refuse to sign this form and that my refusal will not result in the provider conditioning the provision of healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the provider declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the provider declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. *Client initials*:_____

I understand that this authorization will expire on the earliest of the following:
One year from this date or with the following date or event:_____

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing (In keeping with 42 CFR Part 2, clients receiving services related to substance use disorders may orally revoke this authorization). The revocation will only be effective from the date it is received by the provider and will not apply retroactively. *Client initials*:_____

_____ _____
Signature of client or client's representative Date

_____ _____
Clinician Signature Date