Jamie Pedersen
Licensed Professional Clinical Counselor (CA LPC23)

Authorization for Release of Information

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows **Jamie Pedersen, LPCC** to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to Jamie Pedersen, LPCC. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Client Information: (individual whose information will be released)

Name: (First, Middle, Last, Title)

Telephone Number: (including area code)	**Date of Birth:** (Month/Day/Year)

Address: (including zip code)

I authorize **Jamie Pedersen, LPCC** to release my protected health information as described below.

Recipient: (person or organization that will receive your information)

Name: (First, Middle, Last, Title)

Telephone Number: (including area code)	

Address: (including zip code)

Description of the Information to be Released: (what type of information will be released)

Psychotherapy Notes and pertinent psychotherapy information discussed in the session.

Purpose of Release: (Examples: working with referrals such as physician, nutritionist, or other health practitioner.)

NOTE: State law requires that you give specific permission to release the information below. Indicate your permission for release by initialing below.

Substance / Alcohol Abuse: (Initials)	**Mental / Behavior Health:** (Initials)

Expiration: (when this authorization will end)

This authorization will expire on (Month/Day/Year) _____ / _____ / 20____ **OR in the occurrence of the following event** (Examples: until I revoke this authorization; Resolution of a specific issue):

Approval: (You OR your legal guardian must sign and date this form in order for it to be complete.)

I understand that this authorization to release information is voluntary. I also understand that if the person or organization I authorize to receive the information described about is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Signature: By signing below, I authorize the use of my protected health information.

Signature: **Date:** (Month/Day/Year)

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