Empower Therapy for Women, LLC

Office 9, 716 Xenia Ave
Yellow Springs, OH 45387
(937) 662-9080
Empower-Therapy.com

Client Name: _____ Birth Date: _____ SSN: _____

I understand by signing this form, I am allowing Empower Therapy for Women to disclose to and/or obtain information concerning the above named client to:

Name of Person and/or Institution: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

Description of Information to be Disclosed:

____Dates of Treatment ____Psychotherapy Notes
____Diagnosis ____Progress
____Symptoms ____Testing Results
____ Prognosis ____Entire File
____ Treatment Plan ____Other: _____

Method of Communication:

___ Verbal ___ Written ___ Both

I authorize the disclosure of the health information described above for the following purpose:

____Coordination of care with previous or future therapist
____Coordination of care with other healthcare providers
____Provider consultation with other healthcare providers
____Other Reason: _____

List any specific limitations on the uses of this health information that you would like to place on the recipient: _____

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless the provider has already taken action in reliance upon it. I also understand that such revocation must be in writing and received by my provider in order to be effective.

Provider is authorized to disclose the Protected Health Information specifically listed above until:

_____

Signed:_____ Date: _____

Print Name: _____