# Dianna Jurena Counseling

## Authorization for Disclosure and Release of Protected Health Information - PHI

Client Name_____ Date of Birth_____

I authorize Dianna Jurena Counseling to ___disclose to &/or ____ obtain my PHI as explained below that identifies me & to share my PHI with the person(s) &/or agencies below:

Name of person, or title of person or organization:

_____

Address:

_____

Phone & fax number:

_____

Description of information to be disclosed:

_____

_____

Purpose of disclosure:

_____

_____

Expiration date:

_____

Unless otherwise & revoked sooner, this authorization expires on the following date:_____ which is no longer than 1 year.

_____ _____

Signature of Client Date

NOTE for Signature: If the client is a minor, and the treatment provided concerns substance use, diagnosis &/or treatment of a communicable disease &/or pregnancy, this form must be signed by that minor rather than the parent or legal guardian. If a minor is married, has a court order of emancipation, or does not live with and is not supported by the parents or guardians, the minor must be the only one to sign this form.

If you are signing as a representative of the client, please describe your authority to act on their behalf such as power of attorney, healthcare proxy or guardian etc. .

_____ _____

Signature of parent, Guardian or Personal Representative Date