Deborah Tucker, LMFT #17142 Contact info available at www.deborahtuckermft.com

Patient Authorization for Disclosure of Health Information

Patient Name:_____Date of Birth:_____/_____/_____
Address:_____City:_____State:_____Zip:_____
E-mail Address:_____Phone:_____

I request that my protected health information (PHI) from Deborah Tucker LMFT be disclosed to:
Recipient name:_____
Address:_____City:_____State:_____Zip:_____
E-mail Address:_____Phone:_____
Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s):

- ⇨ Entire Record
- ⇨ Diagnosis
- ⇨ Dates of Treatment
- ⇨ Treatment Plan or Goals
- ⇨ Other (please specify): _____
- ⇨ Treatment Progress
- ⇨ Test Results
- ⇨ Session Start/Stop Times
- ⇨ Prognosis

Covering the period of healthcare from:_____to _____

Purpose for disclosure of information: _____

Disclosure Format (Paper is default if not marked):_____US Mail (paper format)_____Fax(healthcare provider only)_____E-mail (secure format)_____E-mail (unsecure format, i.e., Gmail, Yahoo)_____CD/Flash drive – secure format_____Other (please specify)_____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees as authorized by state/federal law.
- I have the right to **REVOKE** this authorization at any time. Revocation must be made in writing and presented or mailed to [*ADDRESS*] (see www.deborahtuckermft.com for current mailing address)
Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will **EXPIRE** on the following date/event/condition:

If I fail to specify an expiration date/event/condition, this authorization will expire one (1) year from the date signed.

- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure.
- I have the right to receive a copy of this signed authorization. A copy or fax of this authorization is as valid as the original.

_____ _____
Signature of Patient or Authorized Representative Relationship to Patient (if applicable)

_____ _____
Print Name Date