

Rebecca Abbott Kelley, LCSW

4096 Barrett Drive
Raleigh NC 27609

Authorization to Use or Disclose Protected Health Information

Client Name: _____

Date of Birth _____

Information to be released to/from:

Rebecca Abbott Kelley, LCSW
4096 Barrett Drive
Raleigh NC 27609

Information to be released from/to:

Name: _____

Address: _____

Phone: _____

Fax: _____

Purpose of Release:

- Legal representation Disability determination Insurance
 Request of the client Continuity of Care/Verbal Communication

Information to be released:

- Initial Evaluation Psychosocial Assessment Progress Notes
 Consultation Report Progress Update/ Verbal Other _____

I understand that I may revoke or terminate this authorization at any time by submitting a written revocation to me, except to the extent that action has already been taken in reliance there on. If not previously revoked, this authorization will expire 6 months from date of signature. I hereby give permission to release the information above which may include information regarding drug/alcohol abuse, treatment, and psychological or psychiatric impairments, HIV and or AIDS or physical conditions.

I understand that the person or organization to which it is sent may disclose information that is disclosed under this authorization again. The privacy of this information may not be protected under the federal privacy regulations.

I understand that I may inspect or request a copy of information (for a fee) that is used or disclosed under this authorization and I may refuse to sign this authorization.

_____ (client signature) _____ (date)

_____ (witness signature) _____ (date)

Rebecca Abbott Kelley, LCSW

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