

SUSAN E. SCHWARTZ, PH.D

Authorization to disclose/obtain protected health information.

CLIENT NAME: _____ DATE OF BIRTH: _____

This authorization must be written, dated, and signed by the client or by a person authorized by law to give authorization. This authorization may be revoked at any time. If it is not revoked, the authorization will remain effective until one year following the date set forth below).

I authorize Susan E. Schwartz, Ph.D. to:

_____ OBTAIN my healthcare information from:

_____ PROVIDE my healthcare information to:

NAME/ORGANIZATION:

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: _____ FAX: _____

Susan E. Schwartz, Ph.D. Jungian Analytical Psychology
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Dr. Susan E. Schwartz may obtain and/or provide the following health care information (initial all that apply). By initialing the spaces below, I specifically authorize the release of the following information:

- Diagnostic Assessments
- Number/Dates of Sessions
- Discharge Summary
- Treatment Summary/Impressions
- Medical History
- Drug and Alcohol Treatment Information All Health Care Information*
- Billing
- In Case of Emergency
- Other (please specify) _____

*This may include records relating to communicable diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such information exists.

This information may be communicated:

- Verbally Only
- Written Only
- Both Verbally and in Writing

The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

Client or Authorized Representative Signature: _____

Date: _____

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