

# SUSAN E. SCHWARTZ

Ph.D. L.P.

**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. L.P. to:

\_\_\_\_\_ OBTAIN my healthcare information from:

\_\_\_\_\_ PROVIDE my healthcare information to:

NAME/ORGANIZATION:

\_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**Susan E. Schwartz, Ph.D. L.P. Jungian Analytical Psychology**  
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602-508-8761/ text:602-369-7149 sesphd@cox.net www.susanschwarzphd.com

# SUSAN E. SCHWARTZ

Ph.D. L.P.

Susan E. Schwartz, Ph.D. L.P. 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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