

Cogent Psychiatric Services

Consent and Authorization for the Release and Disclosure of Protected Health Information

Name of the Patient: _____

Date of Authorization: _____

Authorization Initiated By: _____

Information to be Released: _____

Purpose of Release/Disclosure: _____

Person(s) Authorized to Make the Disclosure: _____

Person(s) Authorized to Receive the Disclosure: _____

This Authorization will expire on _____ or upon the occurrence of the following event:

Consent, Authorization, and Certification:

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Patient's Name: _____ **Date:** _____

Patient's Signature: _____
