Ginger Paskowitz, LSCW
Licensed Clinical Social Worker

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Authorization to Use/Disclose Protected Health Care Information

Patient Name: _____

I hereby, give written consent to have Ginger Paskowitz, L.C.S.W., release, receive and exchange information with _____**(insert name)** concerning my health care.

This request and authorization applies to the following protected health information:

_____INITIAL EVALUATION _____COLLABORATION/TREATMENT PLAN

_____PROGRESS NOTES _____OTHER

Each disclosure made with the client's written consent must be accompanied by the following written statement: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2) The Federal rules prohibit you from making any further disclosure of this information or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

I understand that unless action already has been taken in reliance on this information, I may revoke this authorization at any time by making a written request to Ginger Paskowitz, L.C.S.W.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.

Signature (patient or authorized representative) _____

Date:_____

Relationship/authority (if signed by authorized representative):_____