



**Authorization to Use or Disclose  
Protected Health Information (PHI)**

+	_____	_____
	<b>Patient's Full Name</b>	<b>Patient's Social Security Number/ Medical Record Number</b>
_____	_____	_____
<b>Address</b>		<b>Patient's Date of Birth</b>
_____	_____	_____
<b>City, State Zip Code</b>		<b>Patient's Telephone Number</b>

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me: **The Chester Psychotherapy Group**
2. The following person (or class of persons) may receive disclosure of protected health information about me:

\_\_\_\_\_

**His/Her/Its Name**

\_\_\_\_\_

**Address**

\_\_\_\_\_

**City, State Zip Code**

\_\_\_\_\_

**Phone Number to contact:**

\_\_\_\_\_

3. The specific information that should be disclosed is:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Chester Psychotherapy Group in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for:

7. This authorization expires on \_\_\_\_\_, 20\_\_\_\_\_.

**FEES FOR COPIES:** Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places for minor.\***

<b>Signature of Individual*</b> (The person about whom the information relates) <i>OR, if applicable –</i>	<b>Date of Individual's Signature</b>	<b>Date of Birth or Social Security Number</b>
<b>Signature of Guardian* or Personal Representative of Patient's Estate</b>	<b>Date of Guardian's/Personal Representative's Signature</b>	<b>Description of Authority to Act for the Individual</b>

*A copy of this completed, signed and dated form must be given to the Individual or other Signator.*

Official Use Only		
Received	Date	Processed By