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RELEASE OF INFORMATION
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I,___________________ , with the following date of birth, _______________ authorize Leo P. Taillon, LCSW and Linda N. Taillon, LCPC to release and receive protected health information related to my evaluation, diagnosis, and treatment to:
____, Phone: ____________________
Address:

For the following purpose:
____
Information that I do not authorize to disclose:
____
____

* If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
*You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
*Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
*You do not have to agree to this request to use or disclose your information.

PATIENT AUTHORIZATION

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken on reliance upon it and that in any event this consent shall expire twelve (12) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization.

_______ To release any applicable mental health / substance abuse information to the party listed above.
_______ I DO NOT give my authorization to release any information to any third party.

____________________ ________________ ____________________ _________
(Patient Signature) (Date) (Authorized Representative) (Date)