KATHY RODGERS L.C.P.C.
WEBSITE: KATHYRODGERSLCPC.COM
EMAIL: KATHYRODGERSLCPC@GMAIL.COM // PHONE: 208.863.5592 // FAX: 208.899.4606

CLIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: ______________________________ Date of Birth: ________________
(First, Middle, Last) *(mm/dd/yyyy)*

(Note: This form cannot be used for the re-release of confidential information provided to Kathy Rodgers LCPC, by other individuals or agencies. Such requests should be referred to the original individual or agency.) I authorize the disclosure, exchange, and use of the following information in verbal and/or written form for the purpose of treatment planning and continuity of care.

- ☐ Medical Information
- ☐ Psychological Information
- ☐ Educational/Vocational Information
- ☐ Legal Information
- ☐ Personal Information
- ☐ Coordination of Care
- ☐ Other: ______________________________

This information will be disclosed to/from the following individual or organization:

Organization or Individual: ______________________________

Address: ______________________________

Phone #: ________________ Fax #: ________________

Expiration Date of Authorization: ______________________________

This authorization will be in effect for ONE (1) YEAR unless another date is specified here.

Right to Revoke or Terminate Authorization: You may revoke or terminate this authorization at anytime by submitting a written revocation to: Kathy Rodgers LCPC. 5909 W. State St. Boise, ID 83703
Phone: 208-863-5592 Fax: 208-331-2591

Right of the Individual: You may inspect or copy information used or disclosed under this authorization that has been generated by Kathy Rodgers LCPC. You may refuse to sign this authorization.

Signature of Patient *(If 14yrs or older)*: ______________________________

Printed Name: ________________ Date : ________________

Signature of Guardian *(If patient is under 14yrs old)*: ______________________________

Printed Name: ________________ Date : ________________

Signature of Witness *(if necessary)*: ______________________________