Shannon Loehr, MSW, LCSW

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Authorization for Release of Information

This form, when completed and signed, authorizes Shannon Loehr, MSW, LCSW to release and/or receive protected health information (PHI) to/from those designated below:

I,_____, date of birth_____
authorize Shannon Loehr, MSW, LCSW to:

_____ receive and/or furnish copies of all records including, but not limited to all medical and psychological or mental health records, including test results and raw test data, if so requested, with the following person, agency, or entity:

_____
Person, agency, entity Address and phone

_____ other:
_____

This authorization of release of protected health information (PHI) is for the purpose of

_____ treatment planning and coordination of services
_____ other
:_____

I understand that I have the right to revoke this authorization, in writing, by ending written notification to this office at the address above to the extent that this authorization has not been acted upon. I also understand that Shannon Loehr, MSW, LCSW is not liable for any consequences of the disclosure by this office of the information authorized above. I give this consent voluntarily. If not previously revoked, this consent will terminate 365 days from the date of signing. I understand that information used or disclosed as a result of the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____

Printed Name of Patient or Representative Date

_____

Address of Above Signed