AUTHORIZATION FOR USE OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I, (client's name) _____
First Name Middle Name Last Name

give my permission for Richard Berger LMFTA to obtain/release (circle one or both) information from/to:

Agency Name: _____

Contact Person: _____

Contact Phone Number: (_____) _____ - _____

Information is Limited to:

_____

_____

_____

_____

Date of Birth: __ _/__ _/_ __ Date authorization initiated: __ _/__ _/_ __

Signature of the Client: _____

Signature of Personal Representative: _____

Relationship to Patient if Personal Representative:_____

Date of signature: _____

This Authorization will expire on ___/___/___ or upon the happening of the following

_____