Authorization for Disclosure of Protected Health Information
Shared drive, forms, front desk folder, auth to release PHI 01/20/2023
Individual: _____________________________________ Date of Birth: _____________ LU/LIT ID#:___________________
Description of information to be released: ____
Your initials are required to release any the following protected health information:
___Mental Health Records*; excluding psychotherapy notes ___Drug, Alcohol & Substance Use Records ___HIV/AIDS
*Mental health records will only include dates of service,
s hlfotarm38 Td
tiond
[(a)-3 (ny)-2 ( )]TJ
ET
Q
q
0 0 612 792 re
W* n
B39/TT5/55d
( )Tf
 :88DC
q
0 0 612 co 353TT5/.78 590.02 41.664 0.84 re
f2 rEMC
/P <</MCID 9 >>BDC
q
0 0 612 792 re
W* n
BT
/T39.1 lts of