Kathleen Kozlowski, MS, LPC, NCC
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200 White Road, Suite 208
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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I ____ (DOB________________________)
voluntarily consent to authorize my health care provider ***Kathleen Kozlowski, LPC*** to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name:____

Address:____

Phone: ____

Purpose: I authorize the release of my health information for the following specific purpose:
____. (Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

❑ Only the following records or types of health information:
____.

Term: I understand that this Authorization will remain in effect:

❑ From the date of this Authorization until the date of ______________________.

❑ Until the Provider fulfills this request.

❑ Until the following event occurs:____.

I understand that my health information is protected under the federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act (HIPAA) 25 C.F.R. Parts 160 and 164, and the NJ State Privacy Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. By signing this authorization, I acknowledge:

· This authorization can be revoked in writing.

· I have reviewed the Notice of Privacy Practices.

· Revocation of this disclosure does not affect disclosures already made in reliance with this authorization.

· Information disclosed may be subject to re-disclosure by the recipient and not protected under HIPAA or State law.

· I have the right to a copy of this authorization.

· My treatment cannot be conditional upon signing this release, however, if I refuse it may affect continuity of care.

Name: ____ DOB: _____________________

This form has been fully explained and I certify that I understand its contents. I understand that **Kathleen Kozlowski, LPC**, may not condition my treatment on receiving my signature on this Authorization. I may contact my provider, **Kathleen Kozlowski, LPC**, for answers to my questions about the privacy of my health information at 200 White Road Little Silver NJ 07739, or by telephone at (732)305-0355.

Print Name Signature Date

______________________________ ______________________________ __________________

If Individual is unable to sign this Authorization, please complete the information below:

______________________________ ______________________________ __________________

Print Name of Guardian/ Relationship Signature Date

______________________________ ______________________________ __________________

Witness Print Signature Date