Eastside Modern Family Therapy, LLC

Mental health counseling and consulting services for modern youth and families

Michele Loewy, MS, LMFT, # MFT.LF.60682827

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Authorization for Use and Disclosure of Protected Health Information

Client Name: ___________________________________ **Date of Birth:** ________________________

I, _______________________________________, hereby authorize Michele Loewy, MS, LMFT to:
(Please print client name/legal guardian if under 13)

____________ Obtain information from* and/or ________ to Exchange information with*
(Initial) (Initial)

*the person(s) and/or organization(s) named below:

Name/Organization: ____

Address/Phone (if available):____

I understand my records may contain sensitive information, including but not limited to diagnoses, treatment plans, outcome, assessments, and evaluations. I additionally give permission for verbal consultation and written communication between parties.

I authorize the following information to be disclosed: (Please check each specific authorization)

_____ Mental/Behavioral Health ______ Drug and Alcohol ____STD/AIDS/HIV

_____ Psychiatric ______ Medical/Physical Health

_____ School Records ______ Other: _________________________________

For the purpose of: Coordination of care.____

This authorization is subject to revocation at any time via a written request. If not previously terminated, this consent will expire in (check one:) □_______ **days from the signature date OR □ upon termination of therapy services** with Michele Loewy, MS, LMFT.

____ ________________________________ ________
Signature of Client/Legal Representative Print Name Date

____
Relationship to client if signed by anyone other than client (parent, legal guardian, personal representative, etc.)

____ ________________________________ ________
Signature of Client/Legal Representative Print Name Date

____
Relationship to client if signed by anyone other than client (parent, legal guardian, personal representative, etc.)