Kendra Twitty, LPC
(843) 812-1018

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client's name: ________________________________ **Date of Birth**: __ _/__ _/_ __

Date authorization initiated: __ _/__ _/_ __

Authorization initiated by: ____
Name (client, provider or other)

Information to be Released:
- o Authorization for Psychotherapy Notes ONLY (**Important**: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)
- o Other (describe information in detail): ____

Purpose of Disclosure: The reason I am authorizing release is:
- o My request
- o To discuss co-treatment options regarding the above named client
- o Other (describe):

Person(s) Authorized to Make the Disclosure:
Kendra Twitty, MA, LPC and/or Ann O'Brien, MS, NCSC: 766 Etheridge Road Yemassee, SC 29945

Person(s) Authorized to Receive the Disclosure: ____

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

Authorization and Signature: I authorize the release of my (or my child's) confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions.

Signature of Client:____Date:__________________

Signature of Client's Guardian if a minor (under 18):______________________________Date:__________