Vanita Kunert, LMFT
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Authorization for Use, Sharing, or Disclosure of Protected Health Information

I, _____, DOB, _____ authorize my therapist, Vanita Kunert, MFT to share, release and accept medical and psychological information specifically including:

1. Diagnosis, Assessment, and Treatment Plan, and
2. _____

I am requesting my therapist to release this information for the purpose of: coordinating assessment, and treatment. This authorization is at my request.

This authorization shall remain in effect until _____ (one year from now)

_____
Person Authorized to Receive the Disclosure

This authorization will be revoked with written notification.

I authorize the release of my 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. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient, unless state laws that limit the use cover the recipient. I understand that I have the right to revoke or modify this authorization, in writing, at any time, by sending written notification of that revocation or modification to my therapist's office address. The revocation or modification will not be effective until received.

_____ _____
Signature of Client Date