Suzanne C. Klenck, Ph.D., LLC

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AUTHORIZATION TO SHARE INFORMATION

Client's Legal Name:_____ Date of Birth:_____

I, or my authorized representative, request and authorize that Dr. Klenck share:

_____Any content gathered in therapy

_____Mental health diagnoses and treatment

_____My appointment times, dates, and reasons for the visits

_____*ONLY* the following information (specify):_____

_____

With the Following Individuals:

Full Name:_____ Relationship:_____

Full Name:_____ Relationship:_____

Full Name:_____ Relationship:_____

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Dr. Klenck.

I understand that signing this authorization is voluntary and that Dr. Klenck may not condition treatment, payment, enrollment, or eligibility for benefits on my signing of this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal or state privacy regulations.

This authorization expires (specific date): _____, or when I cancel it in writing _____.
If no expiration date or event is specified, this authorization will expire one (1) year after the date it is signed.

_____ _____

Client Signature Date