Kimberly Yost, JD, LPC-MHSP

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

If you would like Kimberly Yost to contact or communicate with relevant providers or individuals, please complete the form below:

Patient Name: ____

Patient Address: ____

____

Patient Date of Birth: ____

Date authorization initiated (today): ______/_______/_______

Patient or Parent/Guardian Name: (if applicable)

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PLEASE CHECK:

☐ I authorize Kimberly Yost to release my information containing details about the conditions and issues for which I am engaged in counseling.

Information of Person to Receive Disclosure:

Name: ____

Phone Number: ____

Address: ____

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City:___________________________ **State:**________ **Zip:**____________

I give my permission for the following individual or agency to obtain and/or release the protected information checked below about me or my child for use in my therapeutic treatment efforts. 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 the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. At any time, I can revoke this permission by notifying Kimberly Yost in writing. I understand that a revocation will not be retroactive and will not affect disclosures prior to revocation. I understand the information to be released may contain details about any of the conditions/issues for which I am being treated or may be restricted only to generic disclosure about my engagement in counseling, as indicated below. I understand that this information may include medically sensitive material, and I authorize its release for the purposes stated. I understand that information used or disclosed related to this authorization may be subject to redisclosure by the recipient and is subject to the privacy rules of the recipient. I understand this information is being obtained for purposes of therapeutic benefit and/or planning. This disclosure will automatically expire 2 years from date initiated unless directed to expire earlier.

___________________________________ ________________

Your Signature or Parent/Guardian Signature **Date**