SANDRA DONALDSON, MDIV. DMIN.
Pastoral Counseling & Marriage & Family Therapy
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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name_____**DOB**_____

Client Address_____

By signing below, I hereby authorize Sandra Donaldson, MDiv, DMin, to disclose the above-named Client's individually identifiable and protected health information ("PHI") to the person/entity named below for the specific purposes stated below.

Person/Entity_____

Purpose of disclosure_____

Address_____

City/State/Zip_____

1. State any client imposed limitation/s on this disclosure or write "none" in the space below.

2. State any client imposed limitations/s on the disclosure of any specially protected PHI related to communicable diseases such as AIDS, HIV, mental health or psychotherapy services, alcohol or drug abuse treatment or genetic testing or "none" below.

3. I understand that except in the case of alcohol and drug abuse treatment records protected by Federal Regulations (42 CFR part 2), the PHI used or disclosed to the Person/Entity may be subject to re-disclosure and no longer protected.

4. I understand that if I do not specify an expiration date in #1 above, this Authorization will expire in 60 days (180 days for mental health records) from the date that I sign this Authorization.

5. I understand that my signature on this Authorization is voluntary and my refusal to sign will not affect my ability to receive services from Sandra Donaldson, MDiv, DMin. I understand that I have a right to revoke this Authorization at any time in writing, but the revocation will not apply to PHI that has already been released in reliance on this Authorization or to PHI created by Sandra Donaldson, MDiv, DMin. expressly for disclosure to the above-listed Person/Entity.

5. I understand that if I have any questions regarding the use or disclosure of my PHI, I can contact Sandra Donaldson, MDiv, DMin. at any time.

Client/ Personal Representative* Signature_____

Date_____

*If not signed by Client, state relationship to client_____