

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Michael W. Adamowicz, LICSW, LLC
250 Wampanoag Trail, Suite 303
East Providence, RI 02915

Client Name:

Date of Birth:

I authorize the use and/or disclosure of the above-named individual's health information as described in this authorization.

Person/Organization disclosing the information:

Person/Organization receiving/using the information:

Name: _____

Address: _____

Telephone: _____

Fax: _____

The information to be used or disclosed:

The purposes of the request are described below (each purpose must be listed):

() At the request of the individual for his/her own purposes

I understand that the information in the health record may relate to genetic testing or information, sexually transmitted diseases, and/or the results of diagnostic tests used to determine if the individual is infected by the human immunodeficiency virus (HIV). The information may also relate to treatment for alcohol or drug abuse and/or confidential communications between the individual and a psychologist, social worker, sexual assault or domestic violence counselor, and/or psychotherapist. Unless I have indicated otherwise above, I specifically authorize the release of this information.

I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and send my written revocation to Michael W. Adamowicz, LICSW, LLC at the address indicated at the top of this form. I understand that the revocation will not be effective until it is received, and it will not apply to information that has already been released in response to this authorization. I also understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless earlier revoked in writing, this authorization will expire in one (1) year.

I understand that signing this authorization is voluntary and that Michael W. Adamowicz, LICSW, LLC will provide treatment and pursue payment for services regardless of whether I sign this authorization.

I understand that if I authorize Michael W. Adamowicz, LICSW, LLC to disclose information, the recipient of the information might disclose it to others, and that any information disclosed by Michael W. Adamowicz, LICSW, LLC may no longer be protected by the federal rule on the privacy of medical records.

Signature of Client or Authorized Representative

Date

Printed Name of Authorized Representative

Relationship to Client