

**AUTHORIZATION to use and Disclose
Protected Health Information (PHI)**

I am completing this form to allow the use and sharing of Protected Health Information about:

Client's Name: _____

Address: _____

Social Security # and/or DOB: _____

I hereby authorize:

Cord of Three Counseling Services
PO Box 151
Patterson, Georgia 31557
912-282-0992/phone 912-647-0510/fax

To: OBTAIN Protected health Information (PHI) from: -and/or-

RELEASE/Disclose PHI to:

Name/Agency _____

Address: _____

Phone: _____

- **Expiration:** I understand and agree that this authorization will be valid and in effect until _____ unless I choose to revoke it. I understand that after that date or event, no more of this information can be obtained by/released to the person or organization unless I sign a new authorization like this one.
- **Revocation:** I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer, Cord of Three Counseling Services at the address listed above. If I do this, it will prevent any releases after the date it is received but can not change the fact that some information was sent or shared before that date.
- I understand that I do not have to sign this authorization and that my refusal to sign will not be cause to discharge my minor child from obtaining services at Cord of Three Counseling Services.
- I understand that I may inspect and have a copy of the health information described in this authorization.
- I understand that if the person/entity that receives the information is not a healthcare provider or health plan covered by federal regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

Authorized Representatives Printed Name

Date

Authorized Representatives Signature

Cord of Three Staff Signature