AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, legal guardian of _____(DOB: __), hereby authorize Yuko Inzana, LCSW with (609) 917-4011 and address at 141 Wall St. Princeton, NJ 08540 to:
_____ Obtain from the following: _____ Disclose to the following:

Name: _____
Address:_____
Phone : _____ Fax: _____
Email Address: _____

I understand that the specific type of information to be disclosed is information from my records relating to
_____ Treatment history and progress, including previous treatment
_____ Diagnosis and clinical assessment
_____ Social History of family, education, and employment, etc.
_____ Attendance of the treatment
_____ Behavioral concerns and academic performance at school
_____ Other (specify): _____

This protected health information is being used or disclosed for the following purposes (check all that apply):
_____To coordinate care _____To complete client assessment/treatment planning
_____Other, specify_____

Unless sooner revoked, this authorization expires on the following date_____ or as otherwise indicated_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Yuko Inzana, LCSW at 141 Wall St. Princeton, NJ 08540. I understand that a revocation is not effective to the extent that Yuko Inzana, LCSW has relied on the use or disclosure of the protected health information.

I understand that: I have the right to inspect or copy the PHI to be used or disclosed as permitted under federal law; I have the legal right to have specific information within those records withheld; I have the right to receive a copy of this authorization for my records.

Furthermore, unless otherwise requested in writing, the disclosed information will be made in a manner that Yuko Inzana, LCSW deems appropriate and consistent with applicable law, including but not limited to, verbally or paper/electronic format.

I understand that it is possible that the PHI that is disclosed pursuant to this authorization may be redisclosed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations unless a State law applies that is more stringent than HIPAA and provides additional privacy.

_____ _____
Client Date

_____ _____
Parent/Legal Guardian or Personal Representative Date

If you are a personal representative of the above-named individual, please explain your legal authorization to act for this individual. ____Please initial here if you, the client, refuse to sign this authorization.

_____ _____
Signature of Clinician Date

141 Wall St. Princeton, NJ 08540
609.917.4011

www.yukoinzana.com
yinzana@tsecuremail.com