

*Across the Bridge, LLC.*

**AUTHORIZATION FOR USE OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_ (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 \_\_\_ Perform Care referral \_\_\_\_\_

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

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 Witness

\_\_\_\_\_  
Date

*Across the Bridge, LLC.*