Darbonshire LLC, Darby Fox, LCSW
304 Wahackme Road, New Canaan, CT 06840
(203) 313-1662

Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

____ All my health information maintained by the above-named practice

(If applicable, circle "include" or "exclude" for each of the following)

Include or Exclude My health information related to drug or alcohol abuse

Include or Exclude My health information related to psychological or psychiatric conditions

____ My health information relating to the following treatment or condition:_____

____ My health information for the date(s):_____

____ Other: _____

This individual/organization may disclose health information to Darby Fox, LCSW—and Darby Fox, LCSW may disclose health information to this individual/organization:

Name (or title) / organization: _____

Address:_____ City:_____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply):

_____ At My Request

_____ Medical/Psychiatric Continuity of Care

This authorization ends: _____ upon termination of treatment with Darby Fox, LCSW

II. My Rights

I understand I do not have to sign this authorization form in order to get/continue treatment.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no lo

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed name
(if signed on behalf of the patient)

Relationship
(parent, legal guardian, personal representative, etc.)