Dr. Lewis James Jordan, PhD, LMHC
MH 9760

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I (name of client) ______________________________ hereby authorize **Dr. Lewis James Jordan, PhD, LMHC** ("Provider") to disclose to ____ ("Recipient": name, function, and address of the person or entity to whom disclosure is to be made) the following protected health information:

_____ **Entire File**	_____ **Symptoms**	_____ **Prognosis**
_____ **Dates of Treatment**	_____ **Psychotherapy Notes**	_____ **Clinical Test Results**
_____ **Session Start/Stop Times**	_____ **Treatment Plan**	_____ **Other** __________________________
_____ **Diagnosis**	_____ **Progress to Date**	

_____ **Modalities & Frequencies of Treatment Furnished**

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider at: 398 Camino Gardens Boulevard Suite 101 Boca Raton, FL 33432 to be effective.

I understand that Provider cannot condition treatment upon me signing this authorization.

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable Florida law.

Provider is authorized to disclose the protected health information specifically listed above until:

____
Date of Expiration of Authorization
(typically 1 year from the current date).

Signed By: ______________________________ **Date:** _______________

*If signed by other than Patient, please indicate the relationship of Representative to the Patient:

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