SHANTALA BOSS, M.S.
LICENSED MENTAL HEALTH COUNSELOR
REGISTERED PLAY THERAPIST

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Authorization to use and disclose Protected Health Information (PHI)

Client name	Parent/guardian (if applicable)
Client SSN last 4 digits	Client DOB

I hereby authorize Shantala Boss, LMHC to:

release information to (initials)_____obtain records from (initials)_____

Person: Facility:

Street: City: State: Zip:

Telephone#: Fax #:

Initial applicable line or lines: Verbal information regarding treatment_____Progress Notes_____
Diagnostic Interview_____Other client information per client request_____

For the purpose of continuity of care and/or other_____

I understand that I can revoke or cancel this authorization at any time by sending a letter to the provider listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I understand that I do not have to sign this authorization, and refusal to sign will not affect my abilities to obtain treatment from the professional listed above. I understand that I may inspect and have a copy of the written health information described in this authorization. I affirm that I understand everything in this form. I understand the information I am authorizing for release may include information regarding sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, medication management and/or treatment for alcohol or drug dependence.

Client Signature (or parent/guardian):_____ Date:_____

Printed name of client or parent/guardian:_____Relationship to the client:_____

Witness Signature:_____ Date:_____

I acknowledge that I received a copy of this completed form____or declined a copy of this form_____