Sheryl Seliger, LCSW
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Authorization for the Use and Disclosure of Protected Health Information

Authorization to send records, and/or disclose confidential information
Pertaining to: _____

From: Sheryl Seliger, LCSW

To: _____ Phone: _____

To: _____ Phone: _____

To: _____ Phone: _____

To: Sheryl Seliger, LCSW

From: _____ Phone: _____

From: _____ Phone: _____

From: _____ Phone: _____

Once agreed to, you have the right to revoke this authorization as you deem necessary. If you wish to revoke this authorization, please do so in writing. Your care in this office will not be conditioned on you agreeing to this authorization. The information released under this authorization may be re-disclosed by the party receiving the information. We have no control over such re-disclosures.

Print Client Name: _____

Client Signature: _____ Date:_____

If a minor, signature of responsible party:

Name: _____ Relationship to Client: _____

Signature: _____ Date:_____

Unless otherwise indicated, this authorization shall expire six years from the date completed.