Authorization for Disclosure of Protected Health Information

Individual: _____ Date of Birth: _____ LU/LIT ID#:_____

Description of Information to be Released: PSYCHOTHERAPY NOTES

I authorize the following facility to disclose my protected psychotherapy notes:

Name: Lamar University Student Health Center Counseling Department

_____ protected psychotherapy notes :

Person/Organization Name: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

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