Christian Fisher P-LLC

Authorization for Disclosure

Patient Name: _____ Patient Record #: _____

Patient Date of Birth: _____ Medicaid #: _____

I hereby authorize **Christian Fisher P-LLC** to disclose and receive specific patient information about me in a reciprocal exchange of information with the following:

	Person/Agency	Street	City	St.	Zip	Fax
1.						
2.						
3.						
4.						
5.						
6.						

This data shall include (patient initial by each type of information that may be released):

Psychological Evaluation	Diagnosis	Alcohol/Drug Treatment*
Psychiatric Evaluation	Service Plan	Hepatitis
Screening	Progress Notes	Medication Information
Patient Profile	HIV	Financial Reimbursement
Other/Disclosures made regarding...		

* Client must sign, whether a child or adult; information protected by Federal Regulations 42 CFR part 2

Purpose of the disclosure: _X_ Assist with treatment   _X_ Referral   ___ At Request of Patient   ___Other

Client/Legally Responsible Person
Signature _____Date: _____

If not revoked earlier, this authorization expires automatically one year from the date it is signed

This authorization is hereby revoked as of the date noted below:

Client/Legally Responsible Person: _____ Date: _____

The patient and/or legally responsible person has notified me verbally that he/she wishes to revoke this authorization as of the date noted below:

Signed: _____ Date: _____
            Christian Fisher, MSW, LCSW