

# Authorization for Disclosure of Protected Health Information

Individual: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ LU/LIT ID#: \_\_\_\_\_

Description of Information to be Released: PSYCHOTHERAPY NOTES

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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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