PATIENT AUTHORIZATION FOR DISCLOSURE OF PSYCHOTHERAPY NOTES

(All sections must be completed)

VOGELFANGER & STRUBLE CLINIC, PLLC
6005 Park Ave, Suite 630-B, Memphis, TN 38060
Phone: (901)767-1136 Fax: (901) 767-0476

I, _____, hereby authorize Vogelfanger and Struble Clinic, PLLC to
(Patient Name)
disclose psychotherapy notes to:

Facility/Provider Name: _____
Address: _____
Phone Number: _____ **Fax Number:** _____

The information in this authorization is to be disclosed for the following purpose:

_____
_____

I understand that my information may not be protected from re-disclosure by the requester of the information; however Vogelfanger and Struble Clinic will use this information only as authorized by me or otherwise required or allowed by law.

I have the right to revoke this authorization by giving written notification to Vogelfanger and Struble Clinic. Vogelfanger and Struble Clinic must comply except to the extent that they have already acted in reliance upon this authorization.

Patient Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Phone Number:** _____

_____ _____
Signature of Patient or Authorized Representative **Relationship**

_____ _____
Print Name **Date**

This authorization will expire on _____(Date may not exceed one year)