Ellen Shaw-Smith, LICSW, BCN, LLC
104 Russell Street / Hadley, MA 01035
Ph: 413-582-0355 / Fax: 413-587-0903

Authorization for the Release of Protected Health Information

When you complete this form, you are authorizing the disclosure and/or use of PHI, Protected Health Information. If you do not provide all information requested on this form, authorization may not be valid.

Client Name: _____ Date of Birth: ____ ____ ____

I Hereby authorize Ellen Shaw Smith, LICSW, BCN, LLC to:

☐ Release my health information to:
☐ Obtain my health information from:

1) _____
2) _____
3) _____

Purpose of Requested Use or Disclosure:

- ☐ Coordination of care, assessment, treatment and/or follow-up
- ☐ At the request of client
- ☐ Insurance authorization

Information to be Released:

- ☐ All Clinical Information
- ☐ Admission and discharge notes
- ☐ Clinical Information from: _____ to _____
- ☐ Other (specify): _____

Signature: _____ **Date:** ____ ____ ____

This authorization expires ____ ____ ____, or if not specified, one year from date of signing.

Notice of Rights and Other Information:

I understand that I may take back or revoke this authorization in writing at any time, except to the extent that Ellen Shaw-Smith taken action in reliance on this authorization. I understand that to revoke this information, I must provide it in writing to the above address. I also understand that if I refuse to sign it, that it will not affect my ability to obtain treatment from Ellen Shaw-Smith, LICSW, BCN, LLC.