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: (____) ____________________________

7T109.53 Tm( )]TJ Eqq m0 43.560 16.89 539.02 1 28.84 ref Q ET EMC /P <</MCID 3 >>BDC BT3/F2 8.04 Tf1 0 0 1 41 357.53 Tm( )]TJ ET EMC /P <</MCID 4 >>BDC BT3/12.04 Tf1 0 0 1 416.70.53 Tm( )]TJ