

**Kelley Armbruster, LISW, DAPA**  
**Protected Health Information Release Authorization**

I, \_\_\_\_\_ [Insert Name of Client], who's Date of Birth is \_\_\_\_\_,

authorize Kelley Armbruster, LISW, DAPA to disclose to and/or obtain from:

\_\_\_\_\_ the following information:  
[Insert Name of Person or Title of Person or Organization]

**Please initial checked area:**

- |   |   |
|---|---|
| <input type="checkbox"/> Assessment               | <input type="checkbox"/> Medical Information        |
| <input type="checkbox"/> Diagnosis                | <input type="checkbox"/> Educational Information    |
| <input type="checkbox"/> Psychosocial Evaluation  | <input type="checkbox"/> Discharge Plan             |
| <input type="checkbox"/> Psychiatric Evaluation   | <input type="checkbox"/> Continuing Care Plan       |
| <input type="checkbox"/> Treatment Plan           | <input type="checkbox"/> Summary                    |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Progress in Treatment      |
| <input type="checkbox"/> Medication update        | <input type="checkbox"/> Presence and participation |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. (or at the request of the client):

If other purpose, please specify: \_\_\_\_\_  
\_\_\_\_\_

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Kelley Armbruster, LISW, DAPA at 7577 Central Parke Blvd. Suite 313, Mason, Ohio 45040. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: \_\_\_\_\_ or as otherwise indicated: (This must be an event that relates to the individual or to the purpose or use of the disclosure)

\_\_\_\_\_

Conditions

I further understand that Kelley Armbruster, LISW, DAPA will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: \_\_\_\_\_  
\_\_\_\_\_

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that once this information is released that it may not have protection provided by law and may be subject to redisclosure.

I will be given a copy of this authorization for my records.

\_\_\_\_\_  
Signature of Client Date

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

\_\_\_\_ Check here if client refuses to sign authorization

\_\_\_\_\_  
Kelley Armbruster, LISW, DAPA, LLC Date