Kathleen Choe
Licensed Professional Counselor – Supervisor
Equine Assisted Psychotherapist
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Authorization to Obtain/Disclose Health Information

Name of Client DOB SSN

Signature above signifies permission to _____obtain_____disclose health information from/to:

Name of Provider Phone Number

Name of Provider Phone Number

Name of Provider Phone Number

Name of Provider Phone Number

This authorization expires one year from _____
Today's date

I may revoke this authorization at any time prior to its expiration by sending written notification to the parties listed on this form.

Signature of client Today's date