

Pathways to Success  
1887 Gold Dust Lane, Ste. 303, Park City, UT 84060  
P.O. Box 980386, Park City, UT 84098  
435-901-3218 phone/435-655-8855 fax

**AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION**

I authorize Marlo Bennett, LMFT, to use and disclose a copy of the specific health and clinical information described as follows:

\_\_\_\_\_

\_\_\_\_\_

regarding \_\_\_\_\_ to: \_\_\_\_\_  
(name of client) (name of recipient)

\_\_\_\_\_ (address of recipient) \_\_\_\_\_ (phone/fax of recipient)

for the purpose of: \_\_\_\_\_

\_\_\_\_\_

You have the right to: request special restrictions on how your health information is shared and used; request that a specific telephone number or address be used to communicate with you; inspect and receive a copy of your health information, including medical and billing records (a fee may apply); request an amendment to your health information. Requests must be made in writing.

By signing this Authorization, you are directing Marlo Bennett, LMFT, to disclose your health information to another person or organization that may not have, or may not be required to adhere to, the same obligations to protect privacy under state and federal law as does a Licensed Marriage & Family Therapist.

**I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.**

**To the recipient: If the information disclosed pursuant to this authorization includes alcohol or substance use information, you may not further disclose the information unless you have obtained a written release of information from the signer of this Authorization.**

**I have reviewed and I understand this Authorization.**

Client(s) \_\_\_\_\_ Effective Date \_\_\_\_\_

Or

Client(s) Authorized Representative \_\_\_\_\_ Description of Rep.'s Authority \_\_\_\_\_ Effective Date \_\_\_\_\_