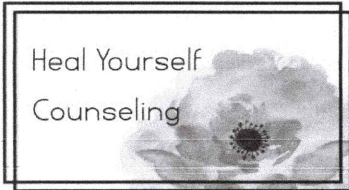

Consent for Release of Information

This authorizes Heal Yourself Counseling to use and disclose the specific health information described below concerning:

Client: ______________________ Date of Birth: __________Therapist: __________________

This will authorize Heal Yourself Counseling to release to/obtain from:

Name: ____

Relationship to Client____

Address: __________________________City: __________________State: _______ Zip: _______

Phone: ____Fax:_____________________________

Information from the medical record maintained from (please list dates such as "all", or 1/21 to 6/21):______________________

The information to be disclosed is (please check all info that you are willing to have exchanged):

___History and intake information	___Progress reports
___Social/ Psychological/ Medical reports	___Treatment plan, goals, and results
___Chemical dependency abuse or diagnosis, history and	___Medications used in treatment
	___Other (specify)

The purpose of the information release is (please check all that apply):

___Diagnosis and evaluation	___Treatment planning
___To facilitate treatment	___Other (specify)

If we are requesting the Authorization from you for our use and disclosure or to allow another health care professional or entity to disclose information: (1) You have the right to inspect a copy of the protected information to be used or disclosed; (2) You may refuse to sign this authorization; and (3) We must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time. This authorization lasts for one year after the date you sign it unless you enter a different date of expiration here:____________________

By signing this authorization, you may be directing us to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

Signature of Client_____________________________ Date_________________