

Hope Counseling and Consulting LLC

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Full Legal Name:	Client Date of Birth:
Name of Parent/Guardian:	
Client Address:	

I hereby authorize **Hope Counseling and Consulting** to:
(Initial Applicable Boxes)

- Obtain Confidential Information From:**
 Disclose Confidential Information To:
 Exchange Confidential Information With:

Name: _____ Phone #: _____

Address: _____

Fax #: _____

1. The purpose for which this information may be disclosed:

- Treatment Insurance
 Care Coordination Other: _____

2. What information may be disclosed:

- Presence in Treatment Psychological Reports/Tests
 Appointment Information Progress in Treatment
 Diagnostic Assessment Discharge Summary
 Diagnosis/Prognosis Other: _____
 Alcohol & Drug Abuse Records (*Protected by Federal Confidentiality Rules 42 CFR Part 2 which prohibit any further disclosure unless further disclosure is expressly permitted or written authorization by the person to whom it pertains or as otherwise permitted by 42 CFR Part 2*).

3. Requested Information Dates from: _____ to: _____.

4. This authorization expires twelve (12) months from the date of my signature below.

5. I understand that:

- the federal Privacy Rule (HIPAA) does not protect the privacy of information if re-disclosed and therefore request that all information obtained be held strictly confidential and not be further released by the recipient. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and state laws.
- I may revoke this consent at any time by completing a written *Revocation of Release of Information Form*. Revoking this authorization does not apply to information that already has been released under this authorization.
- I need not consent to the release of information in order to obtain services. I choose to do so willingly for the purpose(s) specified above.
- My signature below asserts and confirms my legal authority to sign on behalf of the minor.

Signature of Client or Authorized Representative

Date

Printed Name

Relationship to Client

Witness