Authorization for Release of Information

Name: _____ **Date of Birth:** _____

Address: _____ **City, State, Zip:** _____

☐ **I authorize Connie Mitchell, MA, LPC to release information to:**

AND/OR

☐ **I authorize Connie Mitchell, MA, LPC to obtain information from:**

_____ **Name of Provider or Facility**	_____ **Name of Provider or Facility**
_____ **Address**	_____ **Address**
_____ **City, State, Zip Code**	_____ **City, State, Zip Code**
_____ **Phone # / Fax # (Include area code)**	_____ **Phone # / Fax # (Include area code)**

PURPOSE OF THIS REQUEST: (check one) ☐ **Healthcare** ☐ **Insurance Coverage** ☐ **Personal** ☐ **Other**

TYPE OF RECORDS AUTHORIZED: ☐ **Psychiatric/Psychological Evaluation and/or Treatment**
☐ **Drug/Alcohol Evaluation and/or Treatment**

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **Assessments** ☐ **Progress Notes** ☐ **Laboratory Test Results:** _____

☐ **Diagnostic Impression** ☐ **Discharge Summary** ☐ **Treatment Plans** ☐ **Treatment Summary**

☐ **Other (please describe):** _____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**

☐ When the requested information has been sent/received.

☐ 90 days from this date. ☐ Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.
My authorization will expire:

☐ When I am no longer receiving services from Connie Mitchell, MA, LPC.

☐ One year from this date. ☐ Other: _____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a ***written*** request, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of client: _____ Date: _____

Relationship to client: (*if requester is not the client)*: ☐ Parent ☐ Legal Guardian ☐ Other: _____

Client or Representative has been provided a copy of this authorization: _____