Heath Counseling and Consultation Services

Consent Release of Information

Name

DOB

I authorize

Therapist Name

Therapist Address

To disclose and or obtain treatment information from the following:

Name

Address

Phone

Email

Please signature below if you agree to release ALL of your Protected Health Information.

If you are limiting the information that is released, please list ONLY the information you agree to be released:

By signing below I acknowledge that the above information about me may be released, discussed, or disclosed. I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for the regulations. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to my therapist. I understand that once information is disclosed as per my authorization, the recipient, in accordance with eh applicable laws and regulations, may re-disclose the information and it might not be protected by federal or state privacy regulations.

Signature of Patient

Signature of Witness

Date Signed

Printed Name of Witness