TREASURE WELLNESS COUNSELING AND TRAINING CENTER
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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date initiated: _____

Client's Name: _____ _____ _____
First Name Middle Name Last Name

Client's Date of Birth: _____

I, _____ authorize the release of my confidential protected health information, as described in my directions below. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ **Release To:** _____ **Obtain From:** _____ **Exchange With:**

_____
Name of Clinician, Office, Individual

_____ _____ _____
Address Phone Fax

Information to be released:
- ☐ **Authorization for Psychotherapy Notes**
- ☐ **Authorization for History/Intake**
- ☐ **Authorization for Diagnosis**
- ☐ **Authorization for Dates of Treatment/Attendance**
- ☐ **Other (describe information in detail)**: _____

_____

_____

The reason I am authorizing release is:
- ☐ **Evaluation/Assessment and/or Coordinating Treatment Efforts**
- ☐ **Other (describe):**

This Authorization will expire 180 Days after initiated

I understand, that I have the right to refuse the release of any protected health information. I may revoke my consent to release at any time except to the extent that the information has already been released.

Signature of Client: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

Signature of Counselor: _____ **Date:** _____