

**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 \_\_\_\_Social/ Psychological/ Medical reports

\_\_\_\_Chemical dependency abuse or diagnosis, history and

\_\_\_\_Progress reports

\_\_\_\_Treatment plan, goals, and results \_\_\_\_Medications used in treatment

\_\_\_\_Other (specify)

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

\_\_\_\_Diagnosis and evaluation

\_\_\_\_To facilitate treatment

\_\_\_\_Treatment planning

\_\_\_\_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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heal Yourself Counseling⬧info@healyourselfcounseling.com