**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are medical records filed under another name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The person named above hereby requests Examined Life Counseling, PLLC. to RELEASE information to or REQUEST information from:**

Person(s), Company, or Agency:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be released: (Please check next to appropriate information)

\_\_ Assessment \_\_ Diagnosis \_\_ Treatment Plan \_\_ Crisis/Safety Plan

\_\_ Progress Notes \_\_ Discharge Summary \_\_Billing Information/Insurance \_\_ Continuity of Care

\_\_ Legal \_\_ Medication Notes  \_\_ Disability \_\_ Personal

\_\_ Summary or Treatment and Progress

\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do not want disclosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand I have the right to revoke this consent at any time. I understand that if I revoke this consent, I must do so in writing and present the written revocation to Examined Life Counseling, PLLC. I understand that the revocation will not apply to information that has already been released in response to this authorization.

 I understand that once the above information is disclosed, it may be re-disclosed by the recipient and that the information may not be protected by federal privacy laws and regulations.

I understand authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure health care treatment or payment on my behalf unless an authorization for disclosure is required in order for Examined Life Counseling, PLLC. to receive third party payment for services rendered. This consent will expire two (2) years from the signature date OR until such time that I am no longer receiving active treatment from Ben Steel, whichever event occurs first. I may also designate a date or event for this consent to expire, I would like this event to be: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Authorization**:
I attest I have read and was offered a copy this release of information. Examined Life Counseling, PLLC. has answered questions to my satisfaction and I understand the information provided.

Signature of Client or Authorized Representative: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Relationship, if other than client**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**