AUTHORIZATION FOR RELEASE OF INFORMATION

FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
FOR PURPOSES REQUESTED BY PROVIDER

I, _____, authorize Reflections Counseling to release the following information:

__ My entire written record

__ My treatment plan and objectives

__ Billing information

__ Notification of treatment

__ Verbal communication regarding my history and treatment issues

Other_____

I am requesting Reflections Counseling to release this information for the following reasons:

__ Coordination of Care

Other_____

Reflections Counseling should release this information to:

Name_____

Address _____

Phone_____ Fax_____

This Authorization shall remain in effect until my discharge from services.

It is my understanding that this authorization can be revoked, in writing at any time, except to the extent that use and/or disclosure made in good faith may have already occurred in reliance on this authorization, including provision of health care services requiring disclosure to effectuate payment.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

My signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing date of that signature. I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment or eligibility for benefits.

_____ _____
Signature Date

_____ _____
Parent/Guardian/Other legal representative (if client is under 13 years of age) Date

Reflections Counseling
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