

If you would like for me to coordinate care with another provider (e.g. psychiatrist, primary care physician, etc.), please complete the attached form to authorize release of psychotherapy information.



Authorization for Use or Disclosure of Protection Health Information

Client Information

Client Last Name _____ First Name _____ MI ____ DOB: __/__/____
Client Address _____
Client Home Phone: _____ Cell/Work Phone: _____
Client Email Address: _____

Recipient Information

I, _____, do hereby authorize **Abundant Living Counseling & Consultation, PLLC** to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____
Phone: _____
Address: _____

Date of Authorization: __/__/____
Authorization to expire on __/__/____ or upon the happening of the following event: _____

Information to be Released:

(Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)

My entire mental health record

Only those portions pertaining to:

(Specific provider name and/or dates of treatment)

Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

Other: _____

Purpose of Information Release:

- Further mental health care
- Applying for insurance
- At the request of the individual
- Payment of insurance claim
- Vocational rehab, evaluation
- Other (specify): _____
- Legal investigation
- Disability determination

Revocation and Expiration

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I make revoke this authorization, as well as the exceptions to my right to revoke, are explained in Abundant Living Counseling and Consultation’s Notice of Privacy Practices, a copy of which has been given to me.

If not revoked earlier, this consent shall be valid for one year from the date signed unless otherwise indicated below:

Date of expiration, if less than one year

Event, if less than one year

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made 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.

Consumer Signature (if applicable) _____ Date: _____

Legal Guardian Signature (if applicable) _____ Date: _____

Staff Signature _____ Date: _____

If signed by a personal representative:

(a) Print your name: _____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

- Patient is: minor incompetent disabled deceased
- Legal authority: parent legal guardian representative of deceased