Behavioral Health Counseling

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Jamie J. Davis, MA, LPC – owner/therapist

Authorization for Release of Health Information

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

I, _____, understand and agree that:

- This authorization is voluntary;
- I may not be denied treatment or enrollment for health care benefits if I do no sign this form;
- My health information may be subject to re-disclosure by the recipient. If the recipient is not a health care provider, the information may no longer be protected by the federal privacy regulations;
- This authorization will expire _____. I may revoke this authorization at any time by notifying Behavioral Health Counseling in writing; however, the revocation will not influence any actions taken prior to the date my revocation is received and processed.

Who May Receive and Disclose my Information:

I authorize Behavioral Health Counseling, LLC and its affiliates to receive from or disclose my protected health information to the following person(s) or organization(s):
Name: _____

Address: _____ Phone: _____

Type of Information to be Disclosed:

☐ I authorize disclosure of all my health information, including but not limited to medical, pharmacy, dental, vision, mental health, substance abuse, psychotherapy, and health care program information.
☐ I authorize disclosure of the following information: _____

_____

Purpose of Disclosure:

☐My health information is being disclosed at my request or the request of an authorized representative; OR
☐ My health information is being disclosed for the following purpose: _____

_____

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____