Rebecca English Counseling

**Authorization for the Release of Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Rebecca English Counseling located at 722 Weiland Rd. Suite 207 Rochester, NY 14626, phone number of 585-484-0781 and email address of renglishcounselingrochester@gmail.com to:

\_\_\_\_\_\_\_\_\_ Discuss With \_\_\_\_\_\_\_\_\_ Send To \_\_\_\_\_\_\_\_ Receive Information From

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

(Name and Address)

For the specific purpose of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be released:

\_\_\_\_ Medical Evaluation/History/Physical \_\_\_\_ Progress Notes

\_\_\_\_ Psychiatric Evaluation/History \_\_\_\_ Physicians Orders/Notes

\_\_\_\_ Social History \_\_\_\_ Treatment Plans

\_\_\_\_ Psychological \_\_\_\_ Laboratory Test Results

\_\_\_\_ Insurance Records \_\_\_\_ Treatment History

\_\_\_\_ Discharge Summary \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Educational Records \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Court Records \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization will remain in effect for one year following the date of signature. I understand that I have the right to revoke this authorization at any time, but if I do choose to revoke I must do so in writing. I understand that the revocation will not apply to: information that has already been released in response to this authorization or my insurance company (if applicable) when law provides my insurer with right to contest a claim under my policy. I understand that authorizing disclosure of this health information is voluntary and I can refuse to sign. I need not sign in order to assure treatment. I understand that I may inspect/ copy information to be used or disclosed, as provided in HIPAA 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and information may not be protected by federal confidentiality rules.

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

Signature of Client Date

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

Witness Date