Authorization for Release of Information

Name ______________________________ __________________ Date of Birth _____ ______ ________

Client Rights

- You may end this authorization at any time by contacting your therapist.
- If you need to make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your services will not be affected.

Client Authorization

I authorize the following to RELEASE and/or OBTAIN protected health information (PHI) regarding diagnosis or treatment recommended or rendered to the above identified client.

Provider 1	Provider 2
Amber Cox, MSW, LCSW Cox Counseling Services (336) 414-7965 ambercoxlcsw@gmail.com	

- I authorize these agencies to share information verbally or in writing, in person, by mail, phone, fax, and/or email.
- I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations.
- I understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives this request.

Disclosure Scope for PHI Release

Disclosure may include the following verbal or written information (check all that apply):

___ **ANY AND ALL** medical or psychological records necessary for identification, diagnosis, prognosis, or treatment

___ Face sheet
___ Discharge summary
___ Medication records
___ Treatment Plans
___ Verification of Treatment
___ Psychological Evaluation
___ Reason for Treatment
___ Progress & case notes
___ Other: __________________________

___ History & physical
___ School information/educational records
___ Laboratory/Diagnostic testing results
___ Behavioral health/psychological consult
___ ER record report
___ Substance abuse diagnosis/treatment
___ Summary of treatment records & dates
___ Legal/court records

All information I hereby authorize to be obtained from the above-identified source(s) will be held strictly confidential and cannot be released by the providers without my written consent. I understand this authorization will remain in effect for:

__X_ The period necessary to complete all transaction on accounts related to services provided to me.
___ One (1) year
___ Other: _________________

I understand that unless otherwise limited by state or federal regulation and exempt to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

Signature ____ Date______________________

If client is a minor, Signature of Authorized Representative. _________________________ *Print Name:* ____________________
Relationship to client: __ *Parent* __ *Legal Guardian* __ *Court Order* __ *Other:* __________

Witness _____________________________________ Date______________