IRISE Counseling Services, LLC

Authorization for Use or Disclosure of Protected 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 _____ 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 ◯ Payment of insurance claim ◯ Legal investigation ◯ Applying for insurance ◯Vocational rehab, evaluation ◯Disability determination ◯At the request of the individual ◯Other (specify): _____

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.

_____ _____

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 decease ◯