

Graceview Counseling Center

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Request/Authorization to Release Confidential Records and Information

I hereby authorize:

Person or facility: _____

Address: _____

City, State and Zip Code: _____

Phone: _____

To hereby release information from records about _____,

Date of Birth: _____

For the following purpose(s):

- Further mental health evaluation, treatment, or care
- Rehabilitation program development or services
- Treatment planning
- Research
- Other: _____

These records concern the time between _____ and _____.

In the boxes below, the information to be disclosed is marked by an X,

- Intake and discharge summaries
- Medical history and evaluation(s)
- Mental health evaluations
- Developmental and/or social history
- Educational records
- Progress notes, and treatment or closing summary
- Other: _____

Please forward the records to the address in the letterhead at the top of this form.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: Do not release HIV-related information Do not release drug and alcohol information.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

Signature of client	Printed name	Date
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Signature of parent/guardian/representative	Printed name	Relationship	Date
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I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

Signature of witness	Printed name	Date
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Signature of Therapist	Printed name	Date
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- Copy for patient or parent/guardian
- Copy for source of records
- Copy for recipient of records

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named _____.

2. Authorization for release of PHI covering the period of health care (check one)

- a. from (date) _____ - to (date) _____ OR
b. all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):

a. my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR

b. my complete health record *with the exception of the following information*

(check as appropriate):

- Mental health records
 Communicable diseases (including HIV and AIDS)
 Alcohol/drug abuse treatment
 Other (please specify): _____.

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Date: _____

(Signature of Patient)

Keep original, and give copies to your health care provider, agent and family members