

Integrated Counseling Center LLC

Release of Information

Regarding Client:

Full Name	Street Address
Telephone Number	City, State, Zip
DOB	Maiden or Other Name

Health Information Request:

From/To:	From/To:
Individual/Organization	Individual/Organization
Street Address/PO Box	Street Address/PO Box
City, State, Zip	City, State, Zip
Telephone Number	Telephone Number
Fax Number	Fax Number

Specific type of health information to be disclosed:

All health records (last two years) ___ Assessment ___ Diagnosis ___ Treatment Plan ___ Progress Notes ___
Discharge Summary ___ Other: _____

Date(s) of health information to be disclosed: _____

Disclosure Authorized: Verbal ___ Photocopies ___ Fax ___ Written ___ Inspection ___

Purpose or need for disclosure: Continuity of Care ___ Personal use ___ Second opinion ___ Insurance claim payment ___ Application for insurance ___ Legal investigation ___ Disability determination ___ Other: ___
What: _____

I understand that this authorization may be revoked by me at anytime, **(except what the facility has already acted in reliance on from the date of consent)**, by submitting written notice to the Integrated Counseling Center LLC. This consent will remain in effect until the above request is processed or unless otherwise specified and not to exceed a period of one year. Health information that is disclosed to anyone except a covered facility is not covered under the HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations. Signing this authorization is voluntary and I may refuse to sign. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits.

I understand that a photocopy of this consent is as valid as the original. **This consent is valid for a period of one (1) year, unless otherwise specified:** _____

Patient Signature: _____ **Date:** _____

If signed by a person other than the patient, complete the following:

Patient is: Minor ___ incompetent ___ disabled ___ deceased ___

Legal authority: parent of a minor ___ legal guardian ___ next of kin of deceased ___ Power of Attorney for HealthCare (attach POA document)

For minors: Are you the parent of the child? Yes ___ No ___ If yes, have you ever been denied custody of this child? Yes ___ No ___

Authorized legal signature: _____ **Date:** _____