



## AUTHORIZATION FOR RELEASE OF PHI

**ALL FIELDS MUST BE COMPLETED PRIOR TO RELEASE OF INFORMATION**

I authorize Warm Springs Counseling Center to (please check one)  receive or  release health information and records obtained during the course of treatment for:

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

This information is to be (please check one)  disclosed to /  from the following entity:

Name: \_\_\_\_\_

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

- The purpose of the disclosure is:  Communication of care  Legal  Other
- Please describe: \_\_\_\_\_
- Information to be disclosed:

<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Psychological Evaluation
<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Physician Note
<input type="checkbox"/> Termination Summary	<input type="checkbox"/> Psychological Assessments
<input type="checkbox"/> Health & Wellness Evaluation	<input type="checkbox"/> Other _____
- I understand that all or part of the records requested above may include treatment for alcohol/drug abuse, mental health, counseling HIV/AIDS;
- I understand that I may revoke this authorization at any time in writing with the exception of what has already been released pursuant to this release;
- I understand that information used or disclosed in accordance with this release may be subject to redisclosure and may no longer be protected by Federal Law; and
- I understand that treatment is not conditional on my signing this release.
- This authorization will expire in one year from date of signature or on \_\_\_\_\_  
(Date)

Federal Rules prohibit further disclosure of this information unless expressly permitted by written consent of the person to whom it pertains, or their legal representative (CFR 42 Part 2).

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
AUTHORITY (i.e. Parent/Guardian)