

Thorodin Counseling & Consulting, L.L.C. - Authorization to Release Protected Health Information

I _____, hereby authorize Thorodin Counseling & Consulting, L.L.C. or George Macllwinen, MA, to release protected health information, or otherwise, as indicated below to:

Name of organization or person:

Address:

City, state, zip:

Phone:

Information To Be Released:

<input type="checkbox"/> Treatment Status	<input type="checkbox"/> Treatment Discharge Summary	<input type="checkbox"/> Family & Social History
<input type="checkbox"/> History of Present Illness	<input type="checkbox"/> Treatment Summary	<input type="checkbox"/> Cost of Treatment
<input type="checkbox"/> Assessments/Evaluations	<input type="checkbox"/> Medical History & Treatment Summary	<input type="checkbox"/> Services Provided
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Psychiatric History & Treatment Summary	
<input type="checkbox"/> Progress Reports	<input type="checkbox"/> Entire Treatment Record	
<input type="checkbox"/> Other: (specify) _____		

Purpose of Release:

<input type="checkbox"/> Facilitate Psychotherapy	<input type="checkbox"/> Provide information for legal action
<input type="checkbox"/> Coordinate Care	<input type="checkbox"/> Referral for other treatment
<input type="checkbox"/> Meet terms of employment	<input type="checkbox"/> Inform others of treatment status
<input type="checkbox"/> Provide follow-up information	<input type="checkbox"/> Obtain financial benefits
<input type="checkbox"/> Other: (specify) _____	

I understand that my records are protected under federal regulations, including the HIPPA and 42 C.F.R., and cannot be disclosed without any written consent unless otherwise provided for in the regulations. I also understand that the recipient of this information may in some circumstances re-disclose it and the information may no longer be protected by HIPPA. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that my revocation must be in writing.

This consent will automatically expire at the end of one year unless otherwise indicated.

This consent expires on _____ (can be no longer than one year from today’s date).

Signature of client or personal representative Date

If a personal representative is making this request, print name and legal authority

Date of birth: _____ Client name: _____