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

I _____, hereby authorize Thorodin Counseling & Consulting, L.L.C. or George MacIlwinen, 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:

__Treatment Status
__History of Present Illness
__Assessments/Evaluations
__Consultation Reports
__Progress Reports
__Treatment Discharge Summary
__Treatment Summary
__Medical History & Treatment Summary
__Psychiatric History & Treatment Summary
__Entire Treatment Record
__Family & Social History
__Cost of Treatment
__Services Provided

__Other: (specify)_____

Purpose of Release:

__Facilitate Psychotherapy
__Coordinate Care
__Meet terms of employment
__Provide follow-up information
__Provide information for legal action
__Referral for other treatment
__Inform others of treatment status
__Obtain financial benefits
__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: _____