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CLIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

_____ _____
Patient's/Client's Name Birth Date

_____ _____ _____ _____
Street Address City State Zip Code

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying Ross Counseling, LLC and/or David Ross, LMHC in writing, but if I do, it will not have any effect on any actions Ross Counseling, LLC took before it received the revocation.

I hereby request Ross Counseling, LLC and/or David Ross, LMHC to release my confidential health information as specified below.

Person/organization receiving/communicating the information:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: (____)_____Extension _____

Description of individually identifiable health information (check appropriate type(s) of information) to be released:

- ☐ All
- ☐ Treatment Plan(s)
- ☐ Claims
- ☐ Outpatient Progress Reports
- ☐ Eligibility/Benefits
- ☐ Attendance Only
- ☐ Clinical records used to make benefit determinations (may include HIV/AIDS and/or Substance Abuse information)
- ☐ All records relating to a Disability claim
- ☐ Other (describe): _____

The dates of records to be disclosed:
From:_____(MM/DD/YYYY) To:_____(MM/DD/YYYY)

THE CLIENT OR THE CLIENT'S REPRESENTATIVE MUST READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire:

On:_____(MM/DD/YYYY) or one year from the date of the signature below (or as set forth by other applicable federal or state law – see below).

OR

Once the following event occurs:

_____

(Form must be completed before signing)

Signature of Client/Legal Guardian or Client's Representative	Signature of Minor Client	Date
Print Name of Client's Representative	Relationship to the Client	Description of Representative's Authority

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Release expires on the earlier of the specific date stated or 90 days after signed, including authorization to release future health care information, except information to third party health care payors.