INNER AWAKENING
Counseling & Consultation PLLC

AUTHORIZATION FOR RELEASING/ EXCHANGING/ OBTAINING OF INFORMATION FOR INNER AWAKENING COUNSELING & CONSULTATION, PLLC

CLIENT NAME		DATE OF BIRTH
STREET ADDRESS		CITY
STATE	ZIP	PHONE NUMBER

I hereby authorize Inner Awakening Counseling & Consultation, PLLC to *(check all that apply)*:

❒ Exchange with ❒ Release to ❒ Obtain from

Person/organization with whom my information is being exchanged, released, or obtained:

Name:_____

Address:_____

City State Zip_____

Phone Number: (__)_____

Description of individually identifiable health information *(check appropriate type(s) of information)* to be released, exchanged, or obtained:

❒ Diagnostic Assessment ❒ Treatment Plan ❒ Session Reports (Session notes) ❒Attendance Only ❒ Other (describe):_____

I hereby authorize Inner Awakening Counseling & Consultation, PLLC to exchange, release, and/or obtain this information:

❒ verbally only ❒ in written form only ❒ both verbally and in writing

The purpose of this release is *(check all that apply)*:

❒ To further the clinically appropriate coordination of my care
❒ To obtain a copy of my records
❒ To provide verification of my participation in services
❒ Other (describe):_____

The dates of records to be disclosed:

From_____ (MM/DD/YY) To_____ (MM/DD/YY)

Please check *here* if this authorization is to remain open and in effect for the purpose of coordination of my care with the above named person or entity ❒

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 understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above.

I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above. I understand that I may revoke this authorization at any time by notifying Inner Awakening Counseling & Consultation, PLLC in writing, but if I do, it will not have any effect on any actions Inner Awakening Counseling & Consultation, PLLC took before it received the revocation.

_____ _____

Printed Name of Client Signature of Client

_____

Today's Date

_____ _____

Printed Name of Witness Signature of Witness

_____

Today's Date

Date recv'd_____ Processed by:_____ Date Processed:_____

Notes:_____