Authorization to Disclose Health Care Information

Patient name: _____ Date of birth: _____

Please release health care information to:

Name and Organization: _____

Address: _____

City, State: _____Zip Code: _____Phone: _____

By signing this Authorization, I authorize Counseling for Life, Inc. to disclose the following health information:

☐ All Health Information about me, including my clinical records, created or received by Counseling for Life, Inc. This information may include, if applicable:

- Information about mental health diagnosis or treatment including psychotherapy notes.
- Information about diagnosis or treatment for alcohol or drug abuse.
- Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).
- Information about diagnosis or treatment of Sexually Transmitted Disease(s).

☐ All Health Information about me as described in the preceding checkbox, *excluding* the following:

_____

☐ Specific Health Information *including only*:

_____

☐ This release is reciprocal _____initials

For the Purpose(s) of: _____

This authorization ends: (check only one box) ☐ in one (1) year

☐ when the following occurs: _____

Other Important Information

You may refuse to sign or cancel this Authorization at any time, in writing, as allowed by law. This will not affect any actions already taken by the above named clinicians and Counseling for Life, Inc. in reliance upon your original request.

There are three ways to cancel this Authorization:

1) Sign and date a revocation form. This form is available from Counseling for Life; or
2) Submit a signed, dated letter to Counseling for Life, Inc. to cancel the authorization; or
3) Write "CANCEL" on this original form with your signature and the date.

Your cancellation or refusal to sign this Authorization will not affect the commencement, continuation, or quality of your treatment. Once your information is released, Counseling for Life, Inc. has relinquished control of it, and the recipient may re-disclose it and privacy laws may no longer protect it. By signing below you are indicating that you understand all the above stipulations and that you hereby release Counseling for Life, Inc. from any and all legal liability that may arise from the use and disclosure of information as set forth in this Authorization.

_____ _____ _____

Signature of Patient or legally authorized representative Date Time

_____

Witness Signature Date Time