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Patient Authorization for Disclosure of PHI (Personal Health Information)
RELEASE OF INFORMATION

I,_____, wish to obtain a copy of my medical records.

Reason I am requesting my records:
_____ Planning appropriate treatment or program
_____ Continuing appropriate treatment or program
_____ Determining eligibility for benefits or program
_____ Case review
_____ Updating files
_____
Other_____
_____
_

I would like my records sent to:
_____
_____
_____

I would like the following released:

_____ Medical history and evaluation(s)
_____ Mental health evaluations
_____ Developmental and/or social history
_____ Educational records
_____ Progress notes, and treatment or closing summary
_____ Other_____
_____
_____ Treatment & Discharge Planning
_____ Appointment Attendance

Social Security Number:_____
Date of Birth:_____
Phone Number: _____

I understand that this Release of Information expiresone year from today's date: _____ to _____. I also understand that if I have any questions about my clinical records, or the content within, I can contact Anelas Holistic Counseling PLLC, and someone will meet with me to discuss my records.

I understand that this information areprotected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if theyare not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary,and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand thatI have a right to receive a copy of this authorization. I understand that I have a right torefuse to sign this authorization.

If you are the legal guardian or representative appointedby the court for the client, please attach a copy of this authorization to receive this protected health information.

_____
Client Printed Name

_____
Client Signature

_____
Date