Authorization for Disclosure of Protected Health Information

Consumer Information	Consumer Full Name :_____ Consumer Address_____ (City, State, Zip) Date of Birth:_____ Phone Number: _____

Instructions: Fill out form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.

Release Information Between These Parties:

Name: _____ **Address:** _____ **City/State/Zip** _____ **Phone/Fax:** _____	**Name/Facility:** _____Inspirit Counseling LLC_____ **Address:**___709 W 4th St Suite #2 Chadron NE 69337 723 Flack Ave Alliance NE, 69301 **Phone:**_308-430-1944_____ **Fax:**_775-667-6079_____

Purpose of Release:

☐ Consultation
☐ Coordination of care
☐ Records information

Other: _____
_____
_____

Information to be Released:

Release Format: ☐ Paper ☐ Digital File **Release Method:** Mail Pick Up Fax Email

Service Dates: From: _____ To: _____ ☐ Current Treatment Episode

☐ All Records ☐ Clinic Progress Notes ☐ Discharge Summary ☐ Psychological Evals/Assmts ☐ History & Physical ☐ Consultation Notes ☐ Substance Abuse Evals/Assmt ☐ Verbal Discussions ☐ Treatment Plans:

☐ Other:_____

I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I hereby authorize the above facility/providers to disclose applicable information regarding my health to each other concerning the above named patient. I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

This authorization will expire one year from the date of signing unless I indicate an event or earlier date here: _____

Third Party Disclosure: By signing this release for information, understand that if this information is disclosed to a third party, the information may be re disclosed by the person or entity that receives the information and may no longer be protected by federal privacy regulations.

ATTENTION: Please review the information below carefully. If information is missing the request may not be processed.

- If consumer is under the age of 19 a legal guardian MUST sign this form
- If consumer is over the age of 19 consumer MUST sign this form.

Signature *(required)*:	**Date Signed** *(required)*:
Printed Name of Person Signing (If legal guardian signing):	