GCC

Grace Counseling & Consulting, LLC.

Making a lasting difference in the lives of others.

Release of Information

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, _____, (Name of Patient making Request), hereby request a copy of my health records and authorize Grace Counseling & Consulting, (hereafter collectively referred to as "this Practice") to use and disclose a copy of my health records to_____

I prefer my records be sent in the following format, but understand that by law, the records can be sent in any electronic format similar if the format I desire is not available. The format which I prefer to have my electronic records sent is.

□ Email a word document to (email address): _____
□ Fax a copy to (fax number): _____
□ Send a hard copy to (address:_____
□ I will pick up a copy on or after (date): _____
□ Phone calls
□ Appointments (verify or make) □ Payments (call and check balance and pay)

I specifically authorize this Practice to use and disclose verbally, by mail, fax or unencrypted email, the following types of super-confidential information (Initials were appropriate):

□HIV records (including HIV test results) and sexually transmissible diseases
□ Alcohol and substance abuse diagnosis and treatment records
□ Psychotherapy records summary

This release is effective until _____ unless otherwise revoked by written request.

The undersigned does hereby release, hold harmless and agree to indemnify this Practice, its employees, and agents for all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Practice is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that this Practice has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

By Patient: _____ Date: _____
Print Name _____
Patient's Representative: _____ Date: _____
Print Name _____