Compassionate Souls Counseling

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HIPAA Privacy Authorization Form – Release of Confidential Information

I, _____ Alison Garcia and/or Compassionate Souls Counseling to **disclose** or **obtain** protected health information described below

Name: _____

Address: _____

Phone: _____

Secure Fax/Email: _____

For the purpose of:

_____ Continuing Care
_____ Personal
_____ Other

Effective Dates: _____ to _____, or one year from date of signature.

Permission to **release or obtain** information (by facsimile, telephone, face to face or written) :

____ Communicate with the person/organization listed regarding all aspects of my treatment, diagnosis and prognosis

____ **Obtain** ____ **Release my** records*/____ **Obtain** ____ **Release** my **child's** records* to the person/organization listed, including medical, psychological, psychiatric, substance abuse, AIDs-related information, laboratory results and opinion resulting from my contacts with them

____ Write a letter or submit form to the person/organization listed

____ Other: _____

____ **I wish to revoke this authorization effective** _____

Only a summary of services will be provided. Requests for full medical records, including psycho-therapy notes will be denied to an individual

____ I understand that I have the right to revoke this authorization, **in writing,** at any time.

____ I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law and in consideration of this consent; I hereby release Alison Garcia and/or Compassionate Souls Counseling from any and all liability arising there from.

_____ _____
Printed of client or personal representative — Date of Birth

_____ _____
Signature name of client or personal representative — Today's Date

_____ _____
Witness — Today's Date