LifeCare Counseling and Coaching

1601 Jones Franklin Road, Suite 104. Raleigh, NC 27606

(919 851-1527 Fax (919) 851-3555

Authorization to Release Information

AUTHORIZATION TO USE/DISCLOSE

PROTECTED HEALTH INFORMATION

Client Name:_____ Date of Birth:_____/_____/_____

I request and authorize:

LifeCare Counseling and Coaching _____

1601 Jones Franklin Road, Suite 104

Raleigh, NC 27606

Tel: (919) 851-1527 Fax: (919) 851-3555

To release and receive specified Protected Health Information in my client record to and from:

Name:_____

Address:_____

Telephone:_____ Fax:_____

This Authorization includes: (Please initial)

_____Medical/Psychiatric Evaluations _____Telephone Conversations _____Billing

_____Psychological Evaluations _____Progress Notes _____Scheduling

_____Laboratory Reports _____Treatment/Discharge Summaries _____Other

_____HIV ____Information regarding drug or alcohol abuse ____Information regarding sickle cell disease

Dates of records covered by Authorization:_____or all _____

Expiration date of authorization is 2 years from date signed unless otherwise specified:_____

I understand that I can withdraw this authorization at any time by notifying Lifecare Counseling and Coaching in writing.
I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. (52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987)

_____ _____

Signature of Client or Authorized Representative Relationship or Authority to Sign

_____ _____

Date Signed Witnessed by