LifeCare Counseling and Coaching, P.C.
www.lifecarecc.com

Authorization to Release Information

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

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Client/Patient Name:_____ Date of Birth: _____

I request and authorize LifeCare Counseling and Coaching, it's staff and providers to:

☐ Request Information from:

_____
Name (organization or individual)

_____
Street Address

_____
City, State, Zip

_____
Phone

_____
Fax (if needed)

☐ Disclose Information to:

_____
Name

_____
Street Address

_____
City, State, Zip

_____
Phone

_____
Fax (if needed)

I authorize the following information to be disclosed:

☐ All of my health information and records, including information about my appointments, prescription medications, evaluations, labs and billing payment for my care

OR

☐ Only the items checked below:

___ Medical/Psychiatric Evaluations
___ Psychological Evaluations
___ Treatment/Discharge summaries
___ Information regarding drug or alcohol abuse
___ Telephone conversations
___ Progress Notes
___ HIV
___ Information regarding sickle cell disease
___ Billing/Scheduling
___ Lab Reports
___ Other _____

The authorization will expire 2 years from the date on the form.

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. 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/Patient or Auth. Representative

_____
Relationship or Authority to Sign

_____
Date Signed

_____
Witnessed by