Authorization for Release of Information

I hereby authorize the use or disclosure and obtaining of identifiable health information as described below. I understand that if the organization authorized to receive information is not an insurance company or health care provider, this information is unable to be within HIPPA guidelines once disclosed.

Purpose of Release: _____Ongoing Verbal communication _____Copy of Record _____Legal or Insurance Review

_____Authorized Representative's request Other_____

Release To/From: The facility/practice/individual listed below is authorized to release the requested health information:

Abdo Counseling and Consulting, PLLC

1118 D2 Sam Newell Road

Matthews, NC 28105

980-404-2251

Abdocounseling@gmail.com

The facility/practice/individual listed above is authorized to release requested health information listed below for the following dates of service, range of time, and/or events:

From:_____ **To:**_____

This authorization will expire when the requested health information (as noted below), for the requested dates of service, range of time or events is released to the recipient named in this document and the purpose of the release is satisfied.

Check the Specific Information to Be Released:

_____All Records and Details Other (Please Specify): _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, psychological or psychiatric impairments, sexually transmitted diseases, AIDS, AIDS related complex, HIV and co-morbid medical diagnoses.

Name of Patient

Patient Name: _____

Patient Address: _____

Date of Birth:_____ **Phone number Home:**_____**Cell:**_____

Release To:

_____ _____

_____ _____

Patients Rights and Signature:

- I understand that I have the right to revoke this authorization at any time by notifying the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.
- I understand that authorization is voluntary and I can refuse to sign this authorization.
- I understand that I may request a copy of the information (for a copying fee) unless treatment if for third party health information pertinent for employment, disability, legal or research.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME: (Patient/Authorized Representative)_____

SIGNATURE:_____ **DATE:** _____

If Authorized Representative, please indicate relationship to patient: _____

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