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Authorization for Release of Confidential Information

This form, when completed and signed by you, authorizes me to release/receive protected information from your clinical record to/from the person or entity you designate.

I, _____ (Client Name & DOB)

_____ (Parent/Guardian), authorize Lisa A. Murawski as well as her administrative and clinical staff to release/receive the following information pertaining to myself:

Letter stating intake and session dates

Intake Summary and Diagnosis

Any information needed to obtain mental health insurance benefits

Other (please be specific) _____ Tx Planning _____

This information should only be released to/from (name and address of person or entity to which the information is to be released):

Name: _____

Address: _____

Phone: _____

Fax: _____

School

I am requesting my counselor to release/receive this information for the following reasons:

At my request

To obtain mental health insurance benefits

To coordinate treatment efforts

Other (please be specific): _____ Tx Planning _____

I have the right to revoke this authorization, in writing, at any time by sending such written notification to the above office address. However, such revocation will not be effective to the extent that this office has taken action in reliance on the authorization or if this authorization was obtained as a condition for obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my counselor generally may not condition counseling services upon my signing an authorization unless the counseling services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature* of Parent/ Guardian _____

Date _____

Signature of Client _____

Date _____

Print name: _____

Print name: _____

**If a personal representative of the client signs this authorization, a description of such representative's authority to act for the patient must be noted.*