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REQUEST AND AUTHORIZATION FOR PROTECTED HEALTH INFORMATION

Name: ____
Phone: ____
Date of Birth: ____

____ (initial) I hereby give permission to Empower Counseling Center to release, orally or in writing, information concerning me to the person or agency named below.

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Individual or Agency:
Name: ____
Phone: ____
Address: ____

The information to be disclosed is as follows:

- ☐ All information
- ☐ Mental health evaluation- including history, diagnosis, and treatment plan
- ☐ Status in psychotherapy and/or treatment summary
- ☐ Identifying information
- ☐ Other ____

The information disclosed is for the following purpose(s):

- ☐ Continuity of care
- ☐ Coordination of services
- ☐ Documentation of services
- ☐ Referral for evaluation and treatment services
- ☐ Verification and confirmation of benefits
- ☐ Other ____

You have the right to revoke this authorization at any time by sending a written notification to the Center. However, your revocation will be not be effective to the extent that information has already been released. The information disclosed to the recipient of this information may not be protected by privacy laws.

I hereby release the above parties from any legal liability resulting from the authorized release of information.

This consent will expire automatically after one year from the date on which it is signed or on ____ (Specify Expiration Date).

____
Signature & Date