Transitional Life Counseling: Assessment & Consultation LLC

1525 Xenia Avenue Yellow Springs, OH 45387 | Phone: 937-769-5019 | Fax: 937-319-0514

Name of Provider (Circle): **Dr. Rose Mary Shaw Dr. Amy Untied Dr. Jennifer Swain**

Authorization for Release of Protected Health Information

Client Name: _____ Birth Date: _____ SSN: _____

I hereby grant my permission to release, review, and exchange the following information relating to my care between the parties named. This release is intended to cover all services provided by Transitional Life Counseling, LLC. I am aware that once this information is released to another party, it may no longer be protected. I understand that I may further limit the type of exchange between the listed parties.

Transitional Life Counseling

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Yellow Springs, OH 45387

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&

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Purpose of this Request (circle):

Continuity of Care Medical Information Legal Insurance Claim Client Request
Other:_____

Ways Information May Be Shared (circle): Phone Fax Mail Email In Person

The following information pertaining to the client named above from dates: _____

I specify that the release/exchange is to include (choose all that apply):

	Mental Health Records		**Medical Records**		**Academic Records**
	Progress Notes		History and Physical		School Transcript
	Psychological Assessment		Discharge Summary		Individualized Education Plan
	Drug/Alcohol Assessment		Sleep study		School Assessments
	Neurocognitive Evaluation		Pathology/Lab Reports		Other:
	Mental Health Treatment		Operative Reports		
	Drug/Alcohol Treatment		MRI/EEG/EKG/Other		
	Consultation		Current Medications		
	Other:		List of Allergies		
			Emergency Room Report		
			Other:		

- I understand that this information may include details relating to Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), treatment for drugs and alcohol abuse, mental/behavioral health, or psychiatric care.

- I understand that if my protected health information is disclosed to someone who is not required to comply with federal privacy regulations, then such information may be re-disclosed and would no longer be protected.

- I understand I have the right to revoke this authorization at any time. My revocation must be in writing in a letter to Transitional Life Counseling. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

- Unless otherwise revoked, I understand that this authorization will expire one year from the signed date below or on the following date: _____**.**

- I understand that I may refuse to sign this authorization and that Transitional Life Counseling may not condition treatment on the completion of this authorization except as indicated in HIPAA regulations at 45 CFR 164-508(B)(4).

- I certify that I have read and received a copy of this authorization. This authorization supersedes all previous authorizations.

A copy or facsimile of this document will be considered as an original

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

I hereby consent to the above for a minor or person unable to assume personal responsibility.

_____ _____
Signature Date

To the recipient: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosures 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 CFR part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.