AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Full Legal Name: ______________________________ Date of Birth: ______/______/______
Email: ______________________________ Phone Number: ______________________
Address: ____
Street City State Zip

Name of Parent/Guardian *(if applicable)*: ______________________________
Email: ______________________________ Phone Number: ______________________
Address: ____
Street City State Zip

I authorize Skyhook Counseling Center LLC to *RELEASE* and *DISCLOSE* client's protected health information to:

Full Name of Individual/Organization: ______________________________
Email: ______________________________ Phone Number: ______________________
Address: ____
Street City State Zip

I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information:

______ HIV/AIDS information
______ Mental health information
______ Genetic testing information
______ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

I authorize to release and disclose the following information: *(initial one)*

______ All information maintained in my record
______ Only the types of information/records selected and initialed from the following list: ***(initial all that apply)***

______ Attendance
______ Billing Records
______ Clinical Assessment(s)
______ Demographics
______ Diagnosis List
______ Progress/Session Notes
______ Psychiatric Evaluations
______ Psychological Testing
______ Service/Treatment Plans
______ Termination/Transfer Summary
______ Therapist Summaries
______ School Records
______ Other Medical Records (specify) ______________________
______ Other (specify) ______________________

I authorize the information to be used for: *(initial all that apply)*

______ Continuation of mental health care
______ Coordination with medical providers
______ Coordination with education services
______ Completion of evaluation
______ Legal coordination *(specify)* ______________________
______ Other *(specify)* ______________________

I authorize to release and disclose the information from the following time period: *(initial one)*

______ All Dates of Service
______ Limited/Specific Date(s) from ______/______/______ to ______/______/______

Unless revoked, this authorization will expire in: *(initial one)*

______ One year ______ Other *(indicate expiration date or event)*: ______________________

I have read this authorization and I understand it. This completed authorization must be signed by the client or a person authorized by law to represent the client. A copy of this authorization is as valid as the original.

______________________________ ______________________
Signature of Client or Client's Representative **Date**

______________________________ ______________________
Print Name of Client or Client's Representative Description of representative's authority