A HEARTH FOR HEALING COUNSELING CTRE, LLC

AUTHORIZATION AND CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Your Name: _____ Date of Birth: _____

I, the undersigned, authorize and request Joanna Hochfelder, LIMHP at A Hearth For Healing Counseling Ctre, LLC to release and/or obtain the following specific information pertaining to the treatment of to/from:

Person/Organization: _____

Street Address: _____

City/State/ZIP: _____ Telephone: _____

I authorize A Hearth For Healing Counseling Ctre, LLC to (check all that apply):

☐ Exchange with ☐ Release to ☐Obtain from

with the party listed above:

☐ Verbally only ☐ Written form only ☐ Both verbally and in writing

the following health information (initial all that apply):

_____ Psychological Evaluation
_____ Diagnosis
_____ Questionnaire
_____ Substance abuse records
_____ Medical History
_____ Financials
_____ School information
_____ Medication records
_____ Progress Notes
_____ HIV/AIDS lab results & treatment history
_____ Treatment Summary
_____ Other: _____

The specific purpose of this disclosure: ☐Coordinate Care/Treatment Planning, ☐Transfer Care, ☐Academic Planning, ☐Legal, Proceedings ☐Other:_____

I understand that the PHI I have authorized will be held strictly confidential by HIPPA compliant standards.

I understand that this authorization will remain in effect for the period necessary to complete all transactions on accounts related to services provided to me by this office. I understand that unless otherwise limited by state or federal regulations and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. I understand that I must authorize this request in writing to A Hearth For Healing Counseling Ctre, LLC. I understand that my signature on this form is voluntary and that not signing it will not affect the ability to receive treatment at this practice.

I understand that a request to revoke this authorization will not affect any actions taken before the provider receives this request. I understand that any revocation will not apply to any PHI that has already been released in reliance to this authorization and to PHI created expressly for disclosure to the person/entity listed above. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and/or substance abuse records, cannot be disclosed without my consent unless otherwise provided in the regulations.

I understand that if the patient is a minor child, I verify that I am the legal guardian/legal custodian of this child. I understand that any questions I have about the use or disclosure of your PHI can be directed to A Hearth For Healing Counseling Ctre, LLC.

Individual Patient (or Personal/Legal Representative) confirming this authorization (you):

I give my authorization to use or disclose my PHI (Protected Health Information) (you). I give this authorization voluntarily.

Your Printed Name _____ Your Signature _____

Your Address _____

Phone _____Email_____