TRANSITIONAL LIFE COUNSELING: ASSESSMENT & CONSULTATION, LLC

1525 Xenia Avenue Yellow Springs, OH 45387 PHONE: 937-769-5019 FAX: 937-769-5019

Name of Provider (circle one): Dr. Rose Mary Shaw Dr. Frederick Peterson

Authorization for Release of Protected Health Information

Client Name:_____ Birth Date: _____ Social Security #:_____

I hereby grant my permission to release, review, and exchange of the following information relating to my care between the parties named here. 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/Mindfully Well Center
1525 Xenia Ave.
Yellow Springs, OH 45387
Phone: (937) 769-5019
Fax: (937) 769-5019

AND

Name: _____
Address: _____
_____
Phone: (___)_____
Fax: (___)_____

Purpose of this request: (circle all that apply during timeframe of release)

Continuity of care Medical information Legal Insurance claim Client request Other, specify: _____

Ways information may be shared: (circle all that apply during timeframe of release)

Mail Fax Phone In person Picked up

The following information pertaining to the client named above: Dates of treatment: _____

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

	Mental Health Records Requested:
	Mental Health Assessment
	Psychological Assessment
	Drug/Alcohol Assessment
	Neurocognitive Evaluation
	Mental Health Treatment
	Drug/Alcohol Treatment
	Consultation
	Other:

	Medical Records Requested:
	History and Physical
	Discharge Summary
	Sleep Study
	Pathology/Laboratory Reports
	Operative Reports
	MRI/EEG/EKG/other
	Current Medication List
	List of Allergies
	Emergency Room Treatment
	Emergency Room Treatment
	Other:

	Academic Records Requested
	School Transcript (elementary, middle, and high school)
	Individualized Education Plan
	School Assessments (learning disability, reading, accommodations)
	Other:

- I understand that this information may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection, treatment for drug or alcohol abuse, or mental or 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 that I have the right to revoke this authorization at any time. My revocation must be in writing in a letter to Transitional Life Counseling at the addressed listed on this authorization form. 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 hundred and eighty days from the date of this form or on the following date or event: _____
- 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 HIPPA Regulations at 45 CFR 164-508(b)(4)
- I certify that I have read and received a copy of the authorization. This authorization supersedes any and all previous authorizations.

<u>A copy or facsimile of this document will be considered as an original</u>

_____ _____ _____ _____
Client Signature Date Witness Date

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

_____ _____ _____
Signature Date Relationship to client

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 disclosure 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 C.F.R part 2. A general authorization for the 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.