Restoration Counseling, LLC
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AUTHORIZATION TO RELEASE PROTECTED HEALTH AND CONFIDENTIAL INFORMATION

I, _____, authorize Restoration Counseling, LLC and Sheldon McGuire, LMFT, to exchange and release the information specified below with the following person/class of persons (Name, Telephone Number, Address, Relationship to Client):

_____

_____

CLIENT NAME: CLIENT DATE OF BIRTH:

_____ _____

PARENT/LEGAL GUARDIAN (if applicable):

_____

ADDRESS:

_____

INFORMATION REQUESTED: I request and authorize the above-named person or class of persons to exchange and release the information specified below to the above-named person or class of persons (check all that apply):

□Evaluations/Testing/Assessments	**□Psychotherapy Notes**	**□Complete Medical/Mental Health Records**
□Treatment Summary	**□Medications prescribed**	**□Diagnosis/Psychiatric Conditions**
□Drug/Alcohol Abuse Information	**□HIV/AIDs Information**	**□ Treatment Plan**

□Other: _____

Type/Form of Information Requested (check all that apply):
□ Records □ Verbal Communications □ Electronic Communications such as texts or emails

I understand that the information to be released includes information for the following **purpose:**

□ Psychiatric Condition, Psychological Testing/Assessment	**□ Treatment Planning**
□ Rehabilitation program, development, or services	**□ Legal Issues**

□ **Coordination of Care** □ **Consultation/Supervision** □ **Education**

□ **Drug/Alcohol Abuse** □ **HIV/AIDS** □ **Medical Care**

□ **Other:**_____

The information sought in this request is the minimum necessary to accomplish the intended purpose of the request. 45 C.F.R. 164.502(b)(2)(v). (See 65 FED. Reg. 82530). Information may be released verbally, in writing, photocopy, by fax or mail unless client indicates otherwise.

I understand that the information to be disclosed may include any or all information involving psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism, and/or information involving communicable and/or venereal diseases such as HIV/AIDS. **I understand that this authorization will expire in one (1) year from the date of signing, unless otherwise specified here:**

_____

AUTHORIZATION: I understand that the disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility to obtain benefits, unless specified in this form. I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer at the contact information above, or their designee. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. I understand, and I authorize the disclosure of my mental health information to someone who may or may not be legally required to keep it confidential, and understand that it may be re-disclosed and may no longer be protected by the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a reasonable fee will be charged for copies of my mental health record. I understand the facility will provide me a copy of the signed authorization form upon my request. If I have questions about disclosure of my mental health information, I can contact the facility Privacy Officer or their designee. I understand that treatment may not be denied if I refuse to sign this authorization, except: 1) If the authorization is the very reason for seeking the health care (e.g., a pre-employment physical), health care may be denied; or 2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign the authorization: 1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it, and 2) If the authorizing is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes. I understand and affirm, by my signature below, that the benefits and disadvantages of releasing the above information, if known, have been explained to me. **A copy or telefax of this authorization will be as valid as the original.**

_____ _____ _____

Client Signature Printed Name Date

_____

Relationship to Client (if applicable)

****The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR part 2). 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 CFR 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.**