Revived Lives Counseling

Authorization

Client Name _____ Date of Birth_____ Account_____

I hereby authorize the following protected health information (PHI):

__ Intake Details __ Progress __ Recommendations __ Impressions
__ Diagnosis __ History and Physical __ File Notes
__ Other (specify) _____

to be disclosed BY / TO (circle one or both) this person or organization

Revived Lives Counseling • 2430 Plainfield Rd. Suite 2D • Crest Hill, IL 60403 • 779-205-9384

TO / BY (circle one or both) this person or organization

Name _____ Organization _____

Address _____Phone _____

City _____ State _____ Zip _____Fax _____

for the following purpose:

_____

My authorization remains valid and in effect until this date or event:

_____

90 days from signature date if left blank

I understand that

- After the date or event above no additional disclosures will be made without an additional completed authorization form.
- I can revoke this authorization at any time by writing a letter to the disclosing person or organization.
- If I revoke this authorization it will prevent further disclosures of my PHI as of the date the letter is received but cannot reverse disclosures made before that date.
- I do not have to sign this form.
- my refusal to sign this form will not affect my ability to obtain treatment.
- I may inspect the PHI described above and have a copy of it (which may cost a fee).
- If the person or organization is receiving the PHI is not covered by federal privacy regulations, the PHI may be redisclosed and no longer protected by those regulations.

I affirm that everything in this form that was not clear to me has been explained and I believe I understand all of it.

Signature _____ Date _____

If signature is that of a personal representative:

Name _____ Relationship/Authority _____

STAFF USE

I, a mental health professional, have discussed the issues above with the person signing above. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature _____ Name _____ Date _____