



### AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION\*

PATIENT'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

I, \_\_\_\_\_, residing at \_\_\_\_\_, hereby give my consent to Vicki Moody LPC-S, LCDC, NCC, dba Earthwalk Counseling to release and receive personal health information contained in my Clinical Record regarding:

Mental health: \_\_\_\_\_ other: \_\_\_\_\_  
Medical history: \_\_\_\_\_  
Family history: \_\_\_\_\_

to/from:

Recipient/Provider of Confidential Info: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Phone Number(s): \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_

Recipient/Provider of Confidential Info: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Phone Number(s): \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_

for the purpose of ("continuity of care" if left blank):  
\_\_\_\_\_

I understand that this is valid until (indefinite if left blank) \_\_\_\_\_, that I may withdraw my consent at any time, and that I have a right to receive a copy of this authorization form. I also understand that the information being disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by this privacy rule.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\* Compliant with the Health Insurance Portability and Accountability Act (HIPAA).