LIFEMATTERS COUNSELING CENTER
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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Legal Name: _____ DOB: _____
Responsible Party Name: _____ Relationship: _____

I authorize Life Matters Counseling and Health Center and the person or agency listed below to use and/or disclose medical, mental health, and/or substance abuse records pertaining to this client to:

Agency Name: _____
Attn: _____ Email: _____
Phone: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Expiration (Date or Event): _____
Purpose of Release: _____

Description of records I want to share:

☐ Evaluations ☐ Treatment Plan ☐ Two-Way Communication ☐ **Any/All Info**
☐ Diagnosis ☐ Treatment Notes ☐ Compliance Reports ☐ Other:
☐ Prescriptions ☐ Medication Notes ☐ Drug Test Results

I understand that I can end this authorization at any time; this will not include any information already shared. I should ask if I am required to sign this form in order to receive services. If I am court ordered into treatment and I end this authorization, it will likely put me in violation of the court order. Once my records have been shared they may no longer be protected. If this authorization is for a minor, both minor and guardian must sign. I can request a copy of my records in writing, which will be approved by a licensed provider and can take up to 30 days to complete; charges may apply. I can also review my records with my therapist by scheduling an appointment.

By signing this form I attest that I have read and accepted the information outlined above.

☐ I would like a copy of this form for my records
☐ I do not need a copy of this form for my records

_____ _____ _____ _____
Client Signature Date Parent/Guardian/Responsible Party Signature Date

_____ _____
Witness Signature Date