CLIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

RELEASE OF MEDICAL RECORDS

I, _____, wish to obtain a copy of my medical records.
Reason I am requesting my records:
_____
_____

I would like my records sent to:
_____
_____

I would like the following released:
_____Dates of service.
_____A summary of my sessions and treatment.
_____My entire record.
_____Other(explain)_____

Date of Birth:_____

Phone Number:_____

I understand that if I have any questions about my clinical records, or the content within, I can contact Joyce Starks at Complete Connections Couples Counseling Center and someone will meet with me to discuss my records. I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996('HIPAA'), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that that any notice to revoke consent must be in writing.

Client Signature:_____

Date: _____

Witness: _____

Date: _____