Melanie M. Stoudt, LPC

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AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Full Name _____ **Date of Birth** _____

Social Security # _____ **Previous Name** _____

I authorize the disclosure of my Protected Health Information (PHI) by Melanie M Stoudt, LPC to:

Name and Organization: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

I authorize the release of the following PHI:

Initial Assessment/Diagnosis _____ Progress Notes _____

Therapy Progression _____ Evaluations (including testing) _____

Medical/Medication _____ Legal _____

Other (*specify)* _____ _____

The purpose of this disclosure is for:

Coordination of Care _____ Request of Individual _____

This authorization will expire 1 year from the date of signature below unless otherwise specified or revoked prior to that date: _____

I understand that this consent can be revoked or amended at any time, unless the information has already been used or distributed. The request must be in writing to the clinician, as allowed by law.

Once PHI has been disclosed, the clinician has no control over it or how it may be used. The recipient might redisclose it and in some incidents, privacy laws may not protect your information. We will make every reasonable effort to protect your information and advise the recipient of your right to protect your PHI.

_____ _____

Signature of Client or Representative Date

_____ _____

Name of Client Name/Relationship of Representative