Authorization For Release of Information

I hereby authorize the use or disclosure and obtaining of identifiable health information as described below. I understand that if the organization authorized to receive information is not an insurance company or health care provider, the released information is no longer to be protected by federal privacy regulations once it is disclosed.

Purpose of Release: ☐Ongoing Verbal communication ☐Copy of Record ☐Legal or Insurance Review
☐ Authorized Representative's request ☐Other_____

Release To/From: The facility/practice/individual listed below is authorized to release the requested health information:

Name: **Pathways to Growth Counseling**
Jenna Lavoie, MA, LPCA **Telephone:** **(704)-612-4148 ext. 1**
Address: **5200 Park Road Suite 236** **Fax:** **(704) 464-4688**

The facility/practice/individual listed above is authorized to release requested health information listed below for the following dates of service, range of time, and/or events:

From:_____ **To:**_____

This authorization will expire when the requested health information (as noted below), for the requested dates of service, range of time or events is released to the recipient named in this document and the purpose of the release is satisfied.

Check the Specific Information to Be Released:

☐ All Records and Details ☐ Other (Please Specify: _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted diseases, AIDS, AIDS related complex, and/or HIV.

Name of Patient Whose Information Is to Be Released:

Patient Name: _____
First Middle/Maiden Last

Patient Address: _____

Date of Birth:_____ **Phone #'s: Home:**_____**Cell:**_____

Release To: **Name, Address, Telephone/Fax #, and Relationship**

_____ _____

_____ _____

Patients Rights and Signature:

- I understand that I have the right to revoke this authorization at any time by notifying the above name organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to inspect or obtain a copy of the information to be used or disclosed per Pathways to Growth Counseling Notice of Privacy Practices/Policy.
- I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third party can received by health information, such as an employer for return to work evaluation, an insurance company for eligibility, or a research project in which I am participating.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME: (Patient/Authorized Representative)_____

SIGNATURE:_____ **DATE:** _____

If Authorized Representative, please indicate relationship to patient: