AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Client Name: _____ **DOB** (MM-DD-CCYY)**:**_____

I **authorize** Empowering Minds Counseling, and it's providers, to **communicate with, release information to, and obtain records and information** from:

Name:	***Relationship:***	***Contact Information:***

Purpose of Release:
The purpose of this disclosure of information is to share treatment information and to coordinate care.

If other purpose, please specify:_____

Information to be Disclosed (Select all that apply):

☐ Psychiatric Evaluation	☐ Mental Health Evaluation/Assessment
☐ Treatment Plans	☐ Progress Notes
☐ Billing documents (with appointment dates)	☐ Discharge Summaries
☐ Complete Mental Health Record	☐ Other: _____

Expiration. This authorization will expire on the following date: _____ (MM-DD-CCYY). If I do not specify an expiration date, this authorization will expire one year from the date of execution of this authorization.

Revocation. I understand that I have a right to revoke this authorization, in writing, at any time. I further understand that a revocation of the authorization is not effective to the extent that action has already been taken in reliance on the authorization.

Conditions. I further understand that if I refuse to sign this authorization, the consequence will be that no information will be disclosed. Empowering Minds Counseling and its staff will not condition my treatment on whether I give authorization for the requested disclosure. I also have a right to inspect and copy the information that is to be released.

_____ _____
Signature of Individual (age 12 or older) Date

_____ _____
Signature of Parent/Guardian (under 18 or Disabled) Date

Clients ages 12-17 years old are requested to sign and date with co-signature of parent/legal guardian. If signing as a representative of an individual, authority to act must be on file.

THIS FORM MEETS ALL REQUIREMENTS OF 42 CFR PART 2, THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT, AND 45 CFR PARTS 160 & 164 (HIPAA)