Jeff Wilfong, LMFT, LPCC
Phone: (888) 511-4269 Fax: (888) 511-4258
www.alivecounseling.com

Authorization to Release & Obtain Protected Health Information (PHI)

Client Information:

Last Name: _____ First Name: _____ Middle initial: _____

Social Security #: _____ Birth date: _____

Address: _____

Phone number(s): _____

E-mail address: _____

(If applicable) Name of legal guardian: _____

Types of confidential information this release covers: *(initial before each requested type)*

_____ **Entire Medical Record** (**includes everything in below box**)

_____ Mental Health information _____ Alcohol / Drug information _____ HIV / AIDS information

_____ Medication list _____ Treatment Plan _____ Assessment/Summary _____ Diagnoses

_____ Attendance records _____ Account/Billing records _____ Work note for each session

_____ Progress notes pertaining to: _____ *(fill in)*

_____ Any records pertaining to: _____ *(fill in)*

ENTITY TO RELEASE INFORMATION TO OR OBTAIN INFORMATION FROM

Name: _____

Address: _____

Phone number: _____ Fax number: _____

E-mail address: _____

METHOD: *(initial one)*

____ Oral and Written ____ Written only _____ Oral only

EXPIRATION DATE / TERM: The authorization to release / obtain medical records expires on _____ (date) or if left blank, expires 365 days from date of earliest client/legal guardian signature. Under no circumstances will such authorization be valid more than 365 days from date of earliest client/legal guardian signature.

REDISCLOSURE OF RECORDS: This office does not re-disclose records of outside medical offices or other professionals that may be on file.

For release without a client's consent: All legal guardians, custodians of an adult, minor, or emancipated minor, or a representative of a deceased client or those authorized by state law to act on behalf of the client, must attach birth certificate, court order, Power of Attorney, or such legal document granting stated authority, and a copy of state issued identification before any confidential information pertaining to client can be released without client's consent.

AGREEMENT: I/We understand that I/we have the right to receive a copy of the authorization, and that any cancellation or modification of it must be in writing. I/We understand that I/we have the right to revoke this authorization at any time. If confidential information has been shared with above agency before such written modification or revocation was received, this office is not liable, and that all future/subsequent release with above agency will end. I/We understand that I/we do not have to sign this authorization and that my/our refusal to sign will not affect my/our abilities to obtain treatment. I/We understand that if the agency/entity that receives the information is not a health care provider or health plan covered by federal HIPAA privacy regulations, that my/our information may no longer be protected

The below signed individuals allow Alive Counseling (Jeffery D. Wilfong, Marriage, Child, and Family Counseling, Inc.), its officers, employees or contractors, to release the indicated type of protected health information (PHI) to the agency/entity (on page 1) AND allow Alive Counseling to obtain the indicated type of protected health information (PHI) from the agency/entity (on page 1). Therefore, this document allows this office to both release and obtain medical information.

I/We affirm that everything in this form has been explained and by signing this I/we have had the chance to ask any questions and agree to all statements contained within.

For minors (under age 18), at least one legal guardian must sign.

_____	X_____	X_____
Printed Name	Signature	Date
_____	X_____	X_____
Printed Name	Signature	Date
_____	X_____	X_____
Printed Name	Signature	Date
_____	X_____	X_____
Printed Name	Signature	Date

NOTE: PLEASE DO NOT RE-DISCLOSE PHI RECEIVED FROM THIS OFFICE