# I AM AS I AM COUNSELING

331 East Main Street, Carnegie PA 15106 iamasiamcounseling.com

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

| Client Name: | Date: |
|---|---|

I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

| | | |
|---|---|---|
| ☐ Assessment Information | ☐ Updates on progress | ☐ Brief Narrative of Focus of Treatment |
| ☐ Full treatment record | ☐ Information on dates of service | ☐ Behavior Reports |
| ☐ Treatment Plan | ☐ Information on level of participation | ☐ Photographs and other Digital Media |
| ☐ Session Notes | ☐ Other: | |

| ☐ **Approval to Release** | ☐ **Approval to Obtain** |
|---|---|
| I authorize I Am as I Am Counseling to **release** the information checked and/or listed above<br><br>to:_____ | I authorize_____<br><br>to **obtain** the information checked and/or listed above from I Am as I Am Counseling. |

I hereby authorize the above information to be ☐ verbal, ☐ mailed, ☐ faxed, and/or ☐ emailed.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

I understand that I may inspect and copy any information used or disclosed under this authorization.

I hereby release the agency, its employees, officers, and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke this request at anytime by providing the agency with my written notice of such revocation.

I understand that this release of information form is valid for 2 years following the date signed by both parties unless revoked by the service recipient.

Date:_____ Signature of Client/Representative:_____

Printed Name of Client/Representative: _____

Relationship to Client:_____

Date:_____ Signature of Witness:_____

Printed Name of Witness:_____