Chapel Hill Family Counseling
LEAH CROWLING, LMFT

Authorization to Release Protected Information

I_____Date of Birth:_____
authorize Leah Crowling, LMFT, to exchange information with:

Name:_____ City, State:_____

Phone Number:_____ Fax Number:_____

The exchange is to [ ] release and/or [ ] obtain the following PHI [ ] Diagnosis/Assessment
[ ] Summary of assessment/treatment [ ] Testing report [ ] Clinical record notes
[ ] Information needed to file insurance
[ ] Other_____

I am requesting this release of information for the following reason(s):

[ ] At my request [ ] Coordination of care [ ] Treatment planning [ ] Filing of insurance claims [ ] Transfer of care
[ ] Legal consultation [ ] Other:_____

This authorization shall remain in effect until _____ or until such time as
Fill in expiration date

_____
Fill in an event that relates to the individual or the purpose of the use or disclosure

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Chapel Hill Family Counseling, PC. However, I understand that any revocation will not be effective to the extent that Chapel Hill Family Counseling, PC, has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Chapel Hill Family Counseling, PC, generally may not condition psychological or psychiatric services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

X_____ Date:_____
Client/Patient (Adult or over age 12)

X_____ Date:_____
Parent/Guardian of minor or authorized representative (indicate relationship)

X____ Date:____________________

Witness