Riverside Counseling, PLLC

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MEDICAL RELEASE
AUTHORIZATION AND CONSENT TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Clients Name**:** _____ Todays Date**:** _____

Date of Birth:_____ Social Security #:_____

I hereby authorize **Riverside Counseling, PLLC** to Release to [ ] and/or obtain information from [ ]

_____
Name of Person/Organization

Address _____ City:_____ State:_____ Zip Code:_____

Phone:(_____) _____ Fax: (_____) _____

Information to be shared:

☐ Verbal Case Discussion ☐ Psychotherapy Notes

☐ Mental Health Records (Including Treatment Plan and Summery Report)

☐ Psychological Assessment Report ☐ Medical information compiled between_____and_____

☐ Other:_____

The information may be disclosed for the following purpose(s) only:

☐ Transfer to New Therapist/Doctor ☐ Continuation of Care (Specialist) ☐ Records for PCM ☐ Legal

☐ At my/or my guardian's request ☐ Records for School ☐ Case Management with DSS/CPS

☐ Other:_____

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health care records and is not effective as to the health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom the disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the heath care entity.

_____ _____
Printed name of Client Date

_____
Signature of Client

If client is under the age of 18: A [ ] parent [ ] legal guardian must sign this consent for any minor child

_____ _____
Parent/ Guardian printed name Date

_____ _____
Parent/ Guardian Signature Date