



**ABIDE**  
INTEGRATIVE COUNSELING  
SERVICES, LLC  
*"Renewing Hope, Inspiring Growth, Rebuilding Lives"*

## Authorization for Use or Disclosure of Protected Health Information

### Client Information

Client Name \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Client Address \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_

Client Email Address: \_\_\_\_\_

### Recipient Information

I, \_\_\_\_\_, do hereby authorize \_\_\_\_\_ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date \_\_\_\_\_ of \_\_\_\_\_ Authorization: \_\_\_\_\_  
Authorization to expire on \_\_\_/\_\_\_/\_\_\_ or upon the happening of the following event: \_\_\_\_\_

**Information to be Released** (Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)

My entire mental health record

Only those portions pertaining to: \_\_\_\_\_  
(Specific provider name and/or dates of treatment)

Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

Other: \_\_\_\_\_

**Purpose of Information Release:**

- Further mental health care
- Applying for insurance
- At the request of the individual

Payment of insurance claim  Legal investigation  Vocational rehab, evaluation  Disability determination  Other (specify): \_\_\_\_\_

**Authorization and Signature**

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

\_\_\_\_\_  
Signature Date

If signed by a personal representative:

(a) Print your name: \_\_\_\_\_

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

\_\_\_\_\_

Patient is:  minor  incompetent  disabled  deceased Legal authority:  parent  legal guardian  representative of deceased

Legal authority:  parent  legal guardian  representative of deceased

**BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT**

\_\_\_\_\_  
Client Name (Please Print) Date

\_\_\_\_\_  
Client Signature Date  
(If Applicable )

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**Parent's or Legal Guardian's Name (Please Print)**

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**Date**

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**Parent's or Legal Guardian's Signature**

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**Date**

The signature of the Therapist below indicates that they have discussed this form with you and has answered any questions you have regarding this information.

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**Therapist's Signature**

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**Date**