Release of Information Authorization Form

This form, when completed and signed by you, authorizes Yuma Counseling Services to release and/or request protected health information from your clinical record to the person you designate.

Client/Patient Name: ________________________________ Date of Birth___________________

Address____

____
City State Zip Code
Phone #____

I authorize Yuma Counseling Services to release the following information:

☐ Psychotherapy Notes (It is recommended that you discuss this with your therapist prior to checking this box).
☐ Telephone Contact/Consultation
☐ Treatment Summary
☐ Medical Records, **not including psychotherapy notes.**
☐ Other (Please be specific and detailed about your request below)

____

This information should only be ____ exchanged with, ____ released to, and/or ____ obtained from

____
Name of person, party, or agency

____
Address City State/ Zip Code

____
Telephone Number Fax Number Email Address

This authorization shall remain in effect until ________________________ or one year from the date signed.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Yuma Counseling Services. However, your revocation will not be effective to the extent that Yuma Counseling Services has acted in reliance of 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.

Your signature below conveys your understanding that Yuma Counseling Services personnel will not condition counseling services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. You also understand that any release made prior to a revocation, in compliant with this authorization, shall not constitute a breach of your rights to confidentiality.

X__________________________________	**X**__________________________________	**X**____________________
Signature of Self, Parent, or Guardian	**Printed Name**	**Date signed**
X__________________________________	**X**__________________________________	**X**____________________
Signature of Self, Parent, or Guardian	**Printed Name**	**Date signed**

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.