

Angel Landrum LPC-S, LCDC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name:	
Date of Birth:	

I give permission for the following two agencies/persons to share my protected health information:

Name	Angel Landrum LPC-S, LCDC	Name	
Address	3839 Bee Caves Rd 202	Address	
City/State/Zip	Austin, Texas 78745	City/State/Zip	
Phone	(512)791,3811 (512) 900.2848 (Fax)	Phone	
Sent by	Angel Landrum	# Pages	

Information to be shared is limited to: (Please Check)

<input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> Treatment Plan <input type="checkbox"/> Staff Progress Notes <input type="checkbox"/> Diagnosis	<input type="checkbox"/> Narrative Assessments <input type="checkbox"/> Medication Information <input type="checkbox"/> Treatment Plan Reviews <input type="checkbox"/> Doctor Progress Notes <input type="checkbox"/> Other:
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I give special permission to share the following information: (Please Initial)

HIV/AIDS
 Alcohol and Drug Abuse
 Psychotherapy Notes

Approximate Dates of Service	From		To	
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Purpose/Need for Disclosure: (Please Check)

<input type="checkbox"/> Continuity of Care	<input type="checkbox"/> Disability Benefits	<input type="checkbox"/> At My Request
<input type="checkbox"/> Other: Please Specify: _____		

I can cancel this authorization at any time, in writing, to either party, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. I understand neither party can control how the protected health information will be used by the agency/person who receives it under this authorization. A photocopy of this authorization shall be considered as effective and valid as the original

Unless cancelled or otherwise specified, this authorization will expire one year from date of signature.

Other specified expiration date:

Client Signature:	Date:
Legally Authorized Representative Signature (LAR/Parent/Legal Guardian):	Date:
Legally Authorized Representative Printed Name:	Relationship to Client:

Notice to receiving agency/person: This information has been disclosed to you from records protected by Federal confidentiality rules 42CFR Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosures is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.