Altus Counseling Services PLLC
Release of Protected Health Information

I authorize release of Protected Health Information (PHI).

My name - person authorizing release (please print) ____

Note - If you are legal parent or guardian of person whose PHI is to be released, print your name and relationship.

____

Client birth date (if under 18) ____

My permission to release - Altus Counseling Services disclosing information to (please print)

____
(Example - name of doctor, counselor, clinician, agency, healthcare provider, attorney, school or another person)

Information to be released and/or permissions granted (check all that applies)

_____ Complete mental health record
_____ Progress brief – verbal or written
_____ Participation in therapy
_____ Mental health history
_____ Assessment results
_____ Diagnosis

Other____

Right to Revoke: I may revoke this authorization any time, verbally or in writing to Altus Counseling Services.

____
Client / Legal Representative Name (please print)

____
Date

____
Client / Legal Representative Signature