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11879 Kemper Rd Auburn, CA 95608

Kid Power Counseling Protected Health Care Release Form (PHI Release Form)

Date

Month Day Year

Patient Name *

First Name Middle Name Last Name

Parent or Legal Guardian Name *

First Name Middle Name Last Name

Patient Date Of Birth

Month Day Year

E-mail *

example@example.com

Phone Number: *

(123) 456-7890

Patient Mailing Address: *

Street Address

Street Address Line 2

City

State

Zip Code

Your Name

First Name Middle Name Last Name

I request that my protected health information (PHI) from [Healthcare Provider] be disclosed to:

Email

example@example.com

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number

Area Code Phone Number

FAX (Healthcare Provider Only)

Area Code Phone Number

Disclosure format (Paper is the default if not marked)

- ☐ Paper
- ☐ US Mail (Paper format)
- ☐ Fax (Healthcare provider only)
- ☐
- ☐ E-mail (unsecure format, ie Gmail)
- ☐ CD/Flash drive (Secure fomat)
- ☐ E-mail (Secure format)

I authorize the following protected health information to be released from my medical record(s).

- ☐ Entire record
- ☐ Dates of Treatment
- ☐ Treatment progress
- ☐ Session start/stop times
- ☐
- ☐ Diagnosis
- ☐ Treatment plans or goals
- ☐ Test results
- ☐ Prognosis

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees as authorized by state/federal law.
- I have the right to REVOKE this authorization at any time. Revocation must be made in writing and presented or mailed to: 11879 Kemper Rd Suite 12 B Auburn, CA 95603. Revocations will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will EXPIRE on the following date/event/condition: _____
- If I fail to specify an expiration date/event/condition, this authorization will expire one (1) year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure.
- I have a right to receive a copy of this signed authorization. A digital pdf, copy, or fax of this authorization is as valid as the original.

Signature

Print Name

First Name Middle Name Last Name

Relationship to Patient (if applicable)

Purpose for disclosure of information:

Date

Month Day Year