ALLIANCE COUNSELING, LLC **David Clegg, EdD, MEd, LMHC (WA), LPC (AZ)**	
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AUTHORIZATION TO DISCLOSE/OBTAIN PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

(This authorization must be written, dated and signed by the client or by a person authorized by law to give authorization. This authorization may be revoked at any time. If it is not revoked, the authorization will remain effective until one year following the date set forth below).

I authorize Alliance Counseling, LLC/David Clegg, LPC to (please initial applicable):

_____ **OBTAIN** my healthcare information from:
_____ **PROVIDE** my healthcare information to:

Name/Organization:
_____

Address:_____ City:_____ State:_____ Zip: _____

Phone:_____Fax: _____

Disclosure under this Authorization is for the following purpose:

_____

Alliance Counseling, LLC/David Clegg, LPC, may obtain and/or provide the following health care information (**initial all that apply**). By initialing the spaces below, I specifically authorize the release of the following information:

_____ Diagnostic Assessments
_____ Number/Dates of Sessions
_____ Discharge Summary
_____ Treatment Summary/Impressions
_____ Medical History
_____ Drug and Alcohol Treatment Information
_____ All Health Care Information*

_____ Billing
_____ In Case of Emergency _____
Other (please specify):
_____
_____
_____

*This may include records relating to communicable diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such information exists.

This information may be communicated:

_____Verbally Only _____Written Only _____ Both Verbally and in Writing

The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.