Crossway Counseling Center

27625 U.S. Highway 98
Daphne, AL 36526
Phone: (251) 626-7959 Fax (251) 626-6122

Authorization for Disclosure of Protected Health Information Form

I hereby authorize and request my therapist, _____ and his or her administrative staff to release to/obtain from _____. Confidential psychological, psychiatric medical records and opinions. Pertaining to the treatment of _____ for the purpose of continuity of care, verification of services.

Specified information_____

_____

You have the right to revoke this authorization, in writing, at anytime by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on 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.

I understand that my therapist generally may not condition psychological 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.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by recipient of your information and no longer protected by the HIPAA Privacy Rule.

I UNDERSTAND I CAN REVOKE THIS CONSENT AT ANY TIME. HOWEVER, IN ANY EVENT, IT WILL AUTOMATICALLY EXPIRE ONE (1) YEAR AFTER THE DATE BELOW OR SOONER IF I ELECT.

Signature: _____ Date: _____

Witness: _____ Date: _____

PARENT OR GUARDIAN IF UNDER 19 YEARS OF AGE:

Signature: _____ Date:_____