Christy Pulsford MSW, LISW-S, LICDC
GrowthINsight Counseling LLC
8050 Beckett Center Drive Suite 314 | West Chester, OH 45069
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Authorization for Release of Information

I hereby authorize: Christy Pulsford, GrowthINsight Counseling LLC
To release and disclose confidential health information to the person or facility listed below

Name: _____

Address: _____

Phone: _____ Fax: _____

The purpose/reason for this release of information

- ○ at the request of the client/patient
- ○ enhancing the quality of care
- ○ other_____
- ○ coordinating services
- ○ family involvement in care

I authorize the following health information to be released about the below-named patient/client:

Name of Patient/Client: _____ DOB: _____

- ○ Diagnostic Evaluation / Assessment
- ○ Discharge Summary & Treatment Summary
- ○ Treatment Plan
- ○ Consultation Summary
- ○ Progress Notes
- ○ Psychological/Speech evaluation reports
- ○ Medical history & evaluation
- ○ Billing information
- ○ Scheduling information
- ○ Other_____

I fully understand this request/authorization for release of records between my provider and the above-named person or facility. I understand that this authorization is effective immediately and will remain in effect for the duration of the professional relationship for professional services between by my provider and the above-named patient, and for up to 365 days after termination of this relationship. I understand that I have the right to revoke this authorization at any time by submitting a request in writing to my provider.

I understand that I may refuse to sign this authorization, and that my provider may not condition my treatment upon whether I do so. I understand that if I authorize the disclosure of information to someone who is not legally required to maintain confidentiality, the recipient may re-disclose it, and it may no longer be protected. I understand that I have the right to inspect or copy the protected health information to be used or disclosed.

By signing below, I indicate that I have read the Authorization for Disclosure of Health Information and Records, and offer my consent to disclose those records indicated above.

_____ _____ _____
Patient/Client or Parent/Guardian Signature Relationship to Patient/Client Date

_____ _____
Witness or Provider Signature Date