SOMATIC LATITUDE
Therapy & Consultation

555 Poyntz Avenue • Suite 282 • Manhattan, KS 66502
Office: (785) 301-1542 • Fax: (785) 262-8393

RELEASE OF INFORMATION

Client's Name: _____ DOB: _____

I authorize, my therapist, Angela Givian, LSCSW/Somatic Latitude, LLC, to:

_____ Disclose to
_____ Receive from

Name/Company: _____

Address: _____

City: _____ State: _____ Phone Number: _____

Fax Number: _____ Email: _____

Information authorized to be exchanged by:

_____ Mail: Somatic Latitude, LLC, 555 Poyntz Avenue, Suite 282, Manhattan, KS
_____ Fax: (785) 262-8393
_____ Phone: (785) 301-1542
_____ Email (limitations apply due to HIPAA): angela@somaticlatitude.com

For the purpose of: _____ Collaboration
_____ Continuity of Care
_____ Other _____

Information authorized to disclose/receive/exchange:

_____ All information listed below
_____ Complete health record
_____ Other: _____

_____ Progress notes
_____ Treatment plan summary

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature: _____ Date: _____
Relationship to client: _____

Information disclosed by Somatic Latitude, LLC, to the name party on this Release of Information may not be redisclosed unless the person consenting to this Release of Information consents to such redisclosure by written authorization.