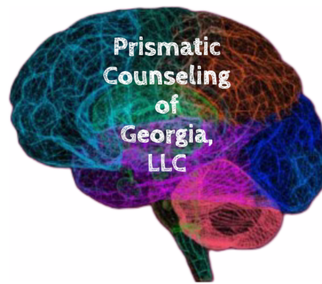

RELEASE OF INFORMATION

Patient Authorization for Disclosure of PHI (Protected Health Information)

I, _________________________, wish to obtain a copy of my medical record and/or information about my treatment for the purpose of ___________________________.

Initial all that apply:

_______ Dates and financial charges of service;

_______ Summary of my sessions and treatment;

_______ My entire clinical record

_______ Other (explain) ____

_______ I give permission for __________________________ (Therapist) to contact and discuss with:

Name/Company for info to be released to: ____

Contact info for release: ____

My Date of Birth is: _________________

My Phone Number is: ________________

If I have questions about current or past charges, my clinical record or content, I may contact Prismatic Counseling of Georgia, LLC to schedule time to discuss my records. Clinical records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); any details contained cannot be disclosed without written consent or other situations covered in HIPAA. This consent may be revoked at any time by contacting Prismatic Counseling of Georgia, LLC; all changes to revoke consent must be in writing.

Signature: ____________________________________ Date: ___________

PRISMATIC COUNSELING OF GEORGIA, LLC
6175 Hickory Flat Hwy, Ste 110-111 Canton, GA 30115 (770) 286-1237 Mobile
www.prismaticcounselingga.com
prismaticcounselingga@gmail.com