**Cathy Champ, MA, LPC-S, LSOTP Laurie Adkins, MS, LPC-Intern**

**Marti Couch, MS, LPC Chris Robinson, MA, LPC-Intern**

**AUTHORIZATION FOR**

**THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, , the undersigned client of Cathy Champ Counseling. PLLC,, do hereby authorize my treating mental health provider, to disclose **any and all** protected health information in my file, included by not limited to psychotherapy notes to the following persons and/or agencies:

I also give authorization to obtain **any and all** protected health information from the following persons and/or agencies:

This information is to be provided at my request for use by the entity(ies) specified above **only** in connection with:

This authorization shall expire on and/or on the conclusion of any and all appeals.

I acknowledge that I have the right to revoke this authorization in writing at any time to the extent Cathy Champ Counseling, PLLC, has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could be possibly still be compelled by Court Order under state law as indicated in the copy of the Privacy Notice of Cathy Champ Counseling, PLLC, that I have received and reviewed.

I acknowledge that I have been advised by my treating mental health provider, of the potential of re-disclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule.

I further acknowledge that the treatment provided to me by Cathy Champ Counseling, PLLC, was not conditioned on my signing this authorization.

Signed this ­day of , 20 .

Client DOB

Parent

Address