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|  | [Elizabeth A. Holmes-Coutracos, LMHC] |

[100 Cummings Center, Suite 435-H] | [Beverly, MA 01915]

Phone: [978-806-6791] | [elizabeth.coutracos@gmail.com] [Website]

# AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTHCARE INFORMATION

This form, when completed and signed, acts as a reciprocal release to authorize Elizabeth Holmes-Coutracos, LMHC to release protected health care information from the clinical record to the person or entity designated and/or from the designated person to Elizabeth Holmes-Coutracos, LMHC.

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| **Client’s Name**: [name] | **Client’s Address**: [Street address] |
| **Date of Birth**: [DOB] |  [City, ST ZIP Code] |
| I request and authorize [Authorized individual]  To release information to:  | [Name] [Street address] [City, ST ZIP Code]Phone: [Phone number] Fax: [Fax number]Email: [Email]**Elizabeth Holmes-Coutracos, LMHC****100 Cummings Center****Beverly, MA 01910****Tel. (978) 806-6791**   |

In addition, I agree to allow Elizabeth Holmes-Coutracos, LMHC to communicate with and release information to the above agency/professional as long as the client is receiving services from both entities.

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| **Client, Parent or Guardian Signature:** |  | Date signed: [Date] |

 (Valid only if signed)

**Specific Information to be Disclosed and Released:**



[My care and treatment\*]\* May not use this release for disclosure of information about drug or alcohol treatment or HIV/Aids status



[My care and treatment\*] [Coordination of Treatment]

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|  | I authorize the release of information pertaining to my care and treatment.\* May not use this release for disclosure of information about drug or alcohol treatment or HIV/Aids status  |
|  | I authorize the release of any information that pertains to my mental health treatment to the person(s) listed above. |

This release may be revoked by you at any time or will automatically expire at the end of treatment. To revoke this authorization, a letter signed by the client, parent or guardian must be sent to Elizabeth A. Holmes-Coutracos. The revocation will be effective upon receipt, but will not effect disclosures already made in reliance on prior consent.

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| Client, Parent, or Guardian Signature: |  | Date signed: [Date] |
| Mental Health Provider Signature: |  | Date signed: [Date] |