Release of Information Form

Dan Anderson, M.A.
Counseling Services

Client Authorization for Release of Confidential Protected Health Information.

By signing, I authorize **Dan Anderson, M.A.** to release confidential protected health information (PHI) about me to _____

_____

This authorization permits **Dan Anderson, M.A.** to use and/or disclose the following individually identifiable health information about me: **Psychotherapy notes and pertinent psychotherapy information discussed in session.**

*NOTE: State law requires that you give specific permission to release the information below. Indicate your permission for release by initialing below.

Substance/Alcohol Abuse _____ (Initials)

Mental/Behavioral Health _____ (Initials)

The information will be used or disclosed for the following purpose: **At the request of the individual.**

This authorization will expire on ____/____/____(mm/dd/yyyy) OR on the occurrence of the following event:_____

I do not have to sign this authorization in order to receive treatment from **Dan Anderson, M.A.** In fact, I have the right to refuse to sign this authorization. When my information is released pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the provider has acted in reliance upon this authorization. My written revocation must be submitted to: Dan Anderson, M.A.

Signed by: _____ _____
Signature of Client or Legal Guardian Date

_____ _____
Print Client's Name Date

_____ _____
Print Name of Legal Guardian (if applicable) Relationship to Client