Authorization to Release Information [Please Print]

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows Associated Counselors of West County, Inc. to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to:
Associated Counselors of West County, Inc. 13610 Barrett Office Dr., Suite 108, Ballwin, MO 63021
Revoking this authorization will not affect any action taken prior to receipt of your written request.

Client Information: (individual whose information will be released)

Name:	**Date of Birth:**
Address:	**Telephone Number:**

Therapist's Name:

I authorize _____ to release my protected health information as described below.

Recipient: (person or organization that will receive your information)

Person's Name or Organization:	**Telephone Number:**
Address:	**Fax Number:**

Description of the Information to be Released: (what type of information will be released)

Check ONLY ONE box:

☐ **Psychotherapy Summary**
☐ **Psychotherapy Case notes**
☐ **Family Psychological History**
☐ **Specific information as described on the line below:***

_____

Purpose of Release: _____

Expiration: (when this authorization will end)**

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

_____
Examples: Until I revoke this authorization; Resolution of a specific issue

Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

I understand that this authorization to release information is voluntary and is not a condition of service by Associated Counselors of West County, Inc. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

_____
(Print Name)

_____
(Signature)

_____
(Date)

OR Personal Representative Information: A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at the Health Plan or submitted with this form.

_____ _____
(Printed Name of Personal Representative) (Relationship to client)

_____ _____ (____)_____
(Date) (Signature of Personal Representative) (Telephone Number)