**Lindsay Cooper LAC, LCPC**

**410 Central Avenue Suite 308**

**PO Box 1432**

**Great Falls, MT 59403**

**406-836-7494**

**Authorization for Release of Health Information**

**Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The client named above is or has been a client of:

Name of Provider: Lindsay Cooper, LAC, LCPC

Mailing Address: PO BOX 1432, Great Falls, MT 59403

Phone: 406-836-7494

Fax: 406-403-0332

The client named above authorizes Lindsay Cooper LAC, LCPC to:

[] Request health information from [] Send health information to

[] Discuss health information with

The client named above authorizes information to be requested or released by representatives of:

Name of Person,

Provider or Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of this authorization is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization expires on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Name of Client or Date

Authorized Representative Authorized Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Witness Name of Witness Date

If not signed by the client, indicate the relationship of authorizing person to client:

[] Parent or guardian of minor child

[] Guardian or conservator of conserved client

[] Beneficiary or personal Representative of a deceased individual

The above named client has the following rights:

This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.

This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to Lindsay Cooper. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.

You have the right to inspect information you are authorizing to be released. This and other specific rights regarding the handling of your health information are outlined in my Notice of Privacy Practices.

The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. I am not responsible for the actions of others who may be provided with information released as a result of this authorization.

You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent the information being requested may assist your health care provider in determining appropriate treatment.

There is a fee for copy of records. Each page is $1.00 and my hourly rate of $180.00 will be billed at 15 minute increments.

PLEASE NOTE: Unless otherwise specified by law, I will release only information that I have created. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.