La Fayette, GA 30728 | | Phone: (706) 954-4324

Authorization for the Release of Protected Health Information

Client Name: _____

Date of Birth: _____

Address:

_____

_____

Phone Number: _____

Authorization Statement:

You are kindly asked to complete the information below to help us process your request securely and with your privacy in mind. By signing this form, you authorize the use or disclosure of your protected health information as specified. The details may be shared with the individual(s) or organization(s) you indicate here:

Releasing Name/ Organization: _____

Releasing Address: _____

Releasing Phone Number: _____

Recipient Name/Organization: _____

Recipient Address: _____

Recipient Phone Number: _____

Please send the records by: ☐ Fax to (706) 430-5271 and/or ☐ Email – calledtoserve30728@rootedingracelafayette.com

Purpose of Disclosure: (Please check all that apply)

- □ Continuity of care
- □ Legal
- □ Personal use
- □ Other: _____

Information to Be Disclosed: (Please check all that apply)

- □ Counseling and/or Coaching Notes
- □ Office Notes
- □ Laboratory Results
- □ Imaging Results
- □ Other: _____

Expiration of Authorization:

This authorization will expire 1 year from the date of signature.

Patient Rights:

We are committed to protecting your rights and privacy. You may revoke this authorization at any time by submitting a written request to your healthcare provider. Please note that any information shared before your request is received may not be retrievable.

Client Name (Print): _____

Client Signature: _____

Date: _____

Counselor Name (Printed): _____

Counselor Signature: _____

Date: _____