Empowering Relief Counseling, PLLC
Affirm * Connect * Empower
5814 S 900 E
Murray, UT 84121
(p) 385-800-3272 * (f) 385-800-3260
http://ercounseling.com

Authorization for Use and Disclosure of Protected Health Information

NOTICE TO ANY AGENCY OR PERSON RECEIVING INFORMATION UNDER THIS AUTHORIZATION: The information referenced below has been disclosed to you from records protected under the federal regulations governing confidentiality and behavioral health records, 42 CFR, part 2 and 45 CFR Parts 160 and 164. Federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by these regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

Full Legal Name:	Date of Birth:	Today's Date:

I hereby authorize Empowering Relief Counseling, PLLC (ERC) to release, request, send, receive, exchange, use or disclose health information about me from/to:

Name:	Phone:	Fax:	Email:

Address:	City:	State:	Zip:

The purpose of this disclosure/request is: _____

Please initial next to each specific record you are authorizing to be released or you are requesting.
Records may be released via telephone, mail, fax, or e-mail.

Release	Request		Release	Request	
•_____	•_____	Clinical Assessment and Diagnosis	•_____	•_____	Medication Records
•_____	•_____	Progress/Office Visit Notes	•_____	•_____	Inpatient and Detoxification Records
•_____	•_____	Treatment Attendance	•_____	•_____	Drug Testing/UA Results
•_____	•_____	Treatment Plan	•_____	•_____	Lab Reports
•_____	•_____	Appointment Information	•_____	•_____	Medical Records
•_____	•_____	Update and Discharge Summaries	•_____	•_____	Legal Information/Records
•_____	•_____	Substance Abuse Records	•_____	•_____	School Information/Records
•_____	•_____	Psychiatric/Mental Health Records	•_____	•_____	Other (Specify) _____
•_____	•_____	Billing Information	•_____	•_____	Other (Specify) _____

I understand that my ability to obtain services with ERC does not depend on signing this authorization unless a court or other authorized third party has required my treatment. I understand that certain disclosures may be made without my permission as required by law and outlined in the ERC Professional Service Agreement. I understand copies of this form may be used in lieu of the original and signatures received by fax will be accepted. ERC cannot guarantee that recipients of the information disclosed through this authorization will not re-disclose to another party. I understand that the recipient may or may not be subject to federal laws protecting health information. ***I understand this authorization may be revoked at any time, in writing, except to the extent that action has already been taken in compliance with this consent.*** ERC and its employees are hereby released from legal responsibility or liability for the release of the information above.

This consent will remain in force for ☐ one (1) year OR ☐ less (to expire on the date specified) _____

_____	_____	_____	_____
Signature	**Date**	**Witness Signature**	**Date**
_____	_____	_____	
Representative Signature	**Date**	**Relationship to client**	

I hereby revoke this authorization _____ _____ _____
Signature **Date** **Time**