Healing Life Counseling

Release of Information Form

Client First and Last Name:

Client Date of Birth:

Guardian First and Last Name (only if client is a minor):

I authorize the scheduling team (Erika Perez and Claudia Perez) at **Healing Life Counseling** to **Receive** clients demographic, medical and mental health information, and any other necessary information (enter it here):

For the **Purpose** of: Scheduling a new client counseling appointment with a therapist at Healing Life Counseling.

From: (Name of referring provider and agency):

Phone:

Email:

Client or Parent/Guardian Signature:

Date:

Referring Provider Signature:

Date:

Additional information about Healing Life Counseling can be found here:
www.healinglifecounseling.com

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.