503 W. Reed St., Upstairs
Moberly, MO 65270
573.823.0720
jdburgeson@gmail.com
www.sunlightcounseling.com

Authorization for Release of Information

Client Name:_____ Date of Birth:_____

I hereby authorize *Sunlight Counseling, LLC* to release information to, and/or receive information from: (Fill in full names, organizations, and phone numbers for all that apply.)

_____ Insurance (Other than Listed below): _____
_____ Missouri Care 1-800-322-6027
_____ Missouri Medicaid 1-800-392-2161
_____ MHNet Behavioral Health 1-800-377-9096
Secondary Insurance:_____

Family Members:_____

School:_____

Family Services:_____

Physician:_____

Juvenile Office:_____

Attorney:_____

Hospital/Other TreatmentFacility:_____

Other Counselor/Therapist:_____

CCMO:_____

Other(s):_____

Authorization for Release of information Continued

I understand that I have the right to receive a copy of this authorization.

I understand I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to a representative of *Sunlight Counseling, LLC*. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected.

I understand that my medical/health records are confidential. I understand that by signing this authorization, I am allowing the release of my behavioral health information. In addition, it may include information relating to sexually transmitted diseases, HIV/AIDS related treatment, other communicable diseases, and/or alcohol/drug abuse treatment.

I understand that authorizing the disclosure of this medical/health information is voluntary. I need not sign this form in order to assure treatment. I understand that for any disclosures of my medical/health information, I can contact a representative of *Sunlight Counseling, LLC.*

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations when applicable (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of the first offense, and not more than $5,000 in the case of each subsequent offense.

This authorization expires one year after it is signed.

Client Signature:_____ Date:_____

Parent/Legal Guardian Signature:_____ Date:_____