Stephanie Reeves, M.Ed, LCPC

Paper Cranes Therapy, LLC

120 E. Lake Street, Suite 305

Sandpoint ID 83864

208-719-1854

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I , authorize the disclosure of health information about myself or my child, to:

Person of Business authorized to disclose/receive/exchange the information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Person of business to disclose/receive/exchange the information:

#  Stephanie Reeves, M.Ed, LCPC- Paper Cranes Therapy, LLC

# 120 E. Lake Street, Suite 305, Sandpoint ID 83864 P: 208-719-1854

Description of information to be disclosed:

Discharge Summary \_\_\_ Psychiatric/Psychological Testing \_\_\_ School Records (Complete) \_\_\_

Psychiatric Testing \_\_\_ Treatment Plan \_\_\_ Progress Notes \_\_\_

Most Recent two years of pertinent information All Psychiatric Records Other (Specify)

For the purpose of:

It has been explained to me the specific types of information requested as well as the benefit and disadvantages of releasing the information (if known). Also, I have been informed that the results of any evaluation, assessment, or treatment are not contingent on my decision concerning this release.

I have carefully read and understand the foregoing. I voluntarily consent to the release of the above specified information to the person or agency named above and acknowledge that some information may include material that is protected by state and federal regulations including Confidentiality of Alcohol and Drug Abuse Patient Records, 42C.F.R. Part 2. I further release this counseling agency and staff from any liability arising from the release of this information to such designated person or agency. This consent is subject to written revocation at any time and unless otherwise specified will expire one year from the date below.

Client Name:

Signature: Date: