CLEAR INNERVISION COUNSELING SERVICE, LLC

WHERE ALL THE PIECES COME TOGETHER ®

Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____ First Name _____MI ___ DOB:___/___/____
Client Address _____
Client Home Phone: _____ Cell/Work Phone: _____
Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below. Name of person/facility to receive medical information: _____ Phone: _____
Address: _____

Date of Authorization: ___/___/_____ Authorization to expire on ___/___/_____ or upon the happening of the following event: _____
_____

19304 Grand River Ave. Detroit, MI 48223

Phone 313.693.4706
Fax 313.693.4820
Email clearinnervisioncs@gmail.com
Website
clearinnervisioncounselingservice.com

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Information to be Released (Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)

☐ My entire mental health record

☐ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)

☐ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

☐ Other: _____

Purpose of Information Release: ☐ Further mental health care ☐ Payment of insurance claim ☐ Legal investigation ☐ Applying for insurance ☐ Vocational rehab, evaluation ☐Disability determination ☐At the request of the individual ☐ Other (specify): _____

Authorization and Signature, I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

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_____ _____

Signature Date

If signed by a personal representative: (a) Print your name: _____ (b) Indicate your relationship to the client and/or reason and legal authority for signing: Patient is: ☐ minor ☐ incompetent ☐ disabled ☐deceased Legal authority: ☐ parent ☐ legal guardian ☐ representative of deceased

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