BURKE + UNGER
LifeWorks
COUNSELING LLC

Authorization for the Release, Use and Disclosure of Protected Health Information

Client Name :_____ Date of Birth: _____

Address:_____

I, _____ authorize _____ to release, exchange or disclose the following information to:

Name: _____ Phone #: _____

Address: _____

_____ Mental Status	_____ Treatment Plans	_____ Progress Notes	_____ Diagnoses
_____ Medical Records	_____ Psychiatric Evaluation	_____ Psychological Test Results	_____ History/Physical Exam
_____ Discharge Summary	_____ Date of Hospitalization	_____ Educational Records	_____ Educational Test/Reports
_____ Psychosocial Report	_____ Attendance Record	_____ Consultation Reports	_____ Court Documents

_____ Other:_____

I consent and agree to the following:

1. The purpose of disclosure is:
   ☐to facilitate and coordinate treatment
   ☐Other(specify):_____
2. I have the right to revoke this authorization in writing at any time; however, I understand that once information has been released or exchanged that information cannot be revoked.
3. Federal Law prohibits the person or organization to which disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is permitted by the written authorization of the person to whom it pertains or as permitted by 42 C.F.R. Part 2.
4. We reserve the right to disclose information as permitted by this authorization in any manner we deem appropriate and consistent with applicable law, including, but not limited to verbally and/or written – whether on paper or electronically.
5. This authorization will terminate at the end of one year or 30 days after the date of termination/discharge.
6. I understand that the provider may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

Client signature _____ Date _____

Parent/Guardian/Personal representative _____ Date_____

Therapist signature _____ Date _____