Authorization to Release and Obtain Information

I _____ authorize Alicia McNany MA, LPC to release my protected health information to:

Name:_____

Address:_____

Phone Number:_____

Or obtain my protected health information from:

Name:_____

Address:_____

Phone Number:_____

Types of records allowed:

_____ All Records

_____ Diagnoses

_____ Progress Notes

_____ Treatment Plan

_____ Start and End dates of treatment

_____ Risk of harm assessment

_____ Summary of progress

I give permission to share information:

_____ From this day ongoing through course of treatment

_____ From this day until the following specific date:_____

_____ For the following specific dates: _____

Purpose of disclosure:

_____ Continuity of care transfer

_____ Coordinating care

_____ Legal Consultation

This authorization can be canceled at any time, in writing, but the cancellation will not affect any disclosures already made prior to the receipt of cancellation notice. This clinician cannot control how the protected health information will be used by this agency/person who receives it under this authorization. Unless canceled or otherwise specified, this authorization will expire one year from date of signature.

Signature: _____ Date:_____