FREE TO FEEL THERAPEUTIC SERVICES, PLLC

RELEASE OF INFORMATION

Name of Client: _____ Date of Birth: _____

I authorize Free to Feel Therapeutic Services, PLLC to:

[ ] Release
[ ] Receive
[ ] Exchange (release and receive)

the following information:

[ ] Medical history and evaluation(s)
[ ] Mental health evaluations including diagnosis
[ ] Developmental and/or social history
[ ] Educational records
[ ] Progress notes, and treatment or closing summary
[ ] Appointment and scheduling information
[ ] Other _____(please list)

for the purposes of:

[ ] Planning appropriate treatment or program
[ ] Continuing appropriate treatment or program
[ ] Determining eligibility for benefits or program
[ ] Case review
[ ] Updating files
[ ] Other _____ (please list)

to/from:

Agency/company: _____

Specific Contact: _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

Updated: 9/7/2023

I understand that:

1) My health information is protected by federal regulation (Alcohol & Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances.
2) I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Revocation of this Release of Information must be received in writing. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.
3) For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III))

Printed Name of Client/Representative: _____

Relationship to the Client: _____

Client/Representative Signature: _____

Date: _____