Dr. Andy Brown, LPC, PLLC

Authorization Form

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I, _____, authorize Dr. Andy Brown to release Progress Notes, Records, Assessments, and Results in written, electronic or oral form.

This information should only be released to: (List name, address, and phone number of the person to whom the information is to be released).

_____

_____

_____

By initialing this section, I authorize the above office to communicate with Dr. Andy Brown regarding my records and progress.
Initial here: _____

This information is being released by the individual/guardian's signature on this form.

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure.

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my counselor generally may not condition counseling services upon my signing an authorization unless the counseling services are provided to me for the purpose of creating health information to a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

_____ _____

Signature of Client Date

** If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.