Sara Morrow, PhD, LLC

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CONSENT FOR RELEASE OF PROTECETED HEALTH INFORMATION

I, the client, _____, _____,
Print Name Date of Birth

Authorize Sara Morrow, PhD, LLC:
To _____ release healthcare information to, and/or
To _____ obtain information from**:**

Name/Organization: _____

Address: _____

Phone: _____ Fax: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

__All dates of treatment / Specified dates of treatment (list)**:** _____

__ Complete Copy	__ Discharge Summary	__ Face Sheet
__ Progress Notes	__ Psychiatric Evaluation	__ School Reports
__ Consultation Notes	__ Psychological Testing	__ Chemical Dependency Evaluation
__ Social History	__ Treatment Plan/Care Plans	__ Immunization Records
__ Medical History	__ Physical Examination	__ Lab Findings
__ Nursing Notes	__ Physician Orders	__ Radiology Reports

__ Other (Specify): _____

I give permission to release these records by: __ Mail ___ Fax ___ Telephone ___ In Person

I give permission to release any information regarding:
__ Psychiatric/Mental Health __ Substance Abuse __ HIV Information

The information will be used /disclosed for the following purposes:
__ Continuing care __ Insurance Purposes __ Personal __ Legal Purposes __ Viewing
__ Collaborative Consultation **__** Other**:** _____

I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization. I understand that I may revoke this release of information at any time by written request.

Client Signature: _____ Date**:** _____

Parent/Guardian**:** _____ Date**:** _____

Clinician Signature: _____ Date**:** _____