



Authorization of Release of Records or Information

Name of Patient

Patient's Social Security Number

I, \_\_\_\_\_ hereby give permission to Patient OR Name of parent/guardian giving permission for minor patient, under 18

Release information to AND/OR Obtain information from:

Name of person, agency, attorney, school counselor, therapist, etc

Address, City, State and Zip Code

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient or parent/guardian must initial each item to be released or obtained

(check one) My Entire Record OR Only the following information

(check all that apply)

- Financial Information (Account balance, insurance, or anything pertaining to billing)
Scheduling information (Inquire about, make, or cancel appointments)
Diagnosis/Assessment
Treatment Plan and recommendations
Progress Reports of treatment
Substance/Abuse Evaluation
Psychological Testing results
Other (specify)

Information may be released in the following manner (check all that apply)

Verbal Photocopy Written Other

The consent form will remain in effect (check one)

from to OR until the consent is revoked in writing

Eden Counseling Center (ECC) has informed me of the HIPAA regulations governing the sharing of protected health care information pertaining to my treatment. I understand that this consent may be revoked in writing at anytime except in the event where legal action has been taken.

Signature of Patient Date

Parent, guardian, or authorized patient representative must sign if patient is a minor or it is otherwise required:

Signature Date Printed Name Relationship to patient

Date: \_\_\_\_\_ Witness: \_\_\_\_\_ 04/2010