Authorization of Release of Records or Information

_______________________________ __________________________ _______________
Name of Patient | Patient's Social Security Number | Patient's birth date

I, __________________________________hereby give permission to release information to:
Patient OR Name of parent/guardian giving permission for minor patient, under 18

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

____
Address, City, State and Zip Code

Phone:__________________________ Fax:_____________________________

Please release the following records from January 2009- present
(check the records you wish to be released)

_____Diagnosis/Assessment/Treatment Plan/Progress Notes
_____Medication records

The consent form will remain in effect (*check one)*

_____from _____________to_____________

_____until the consent is revoked in writing

I understand that my records will be photocopied and mailed or faxed to the entity named above. 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 of parent or authorized representative | Date

______________________________ ______________________________
Printed Name | Relationship to patient

Witness:_________________________ Date:_____________________

NOTE: If Release of Information form is being faxed it must be accompanied by a picture id of the patient or if patient is a minor the id of the adult/responsible party making the request.

Eden Counseling Center
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