3465 National Dr., Suite 215
Plano, TX 75025

Authorization for Release of Confidential Protected Health Information (PHI)

Printed Full Legal Name: _____Date of Birth: _____

I hereby authorize Great Life Counseling Center & its representatives to obtain information from and/or release information to the person and/or agency indicated below for the purpose of treatment or_____.

Name of person and/or agency: _____

Email or Mailing address: _____

_____

Phone: _____ Fax: _____

By checking below, I specifically authorize the release of the following information:

PSYCHOTHERAPY/COUNSELING & ASSESSMENT	**PSYCHIATRIC/MEDICAL RECORDS**
____ *Summary of care	____ *Summary of Care
____ Progress Notes	____ Progress notes
____ Assessments (Diagnosis, Testing, Reports)	____ Assessments (Diagnosis, Testing, Reports)
	____ Psychiatric (Notes, Medications, Referrals)
	____ Drug and alcohol information
	____ HIV/AIDS related test results & information
____ Information specific to:_____	_____Information specific to:_____

*I understand that the information to be used or disclosed if this item is checked may include information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care.

Specific conditions or limitations of the information to be released include:_____

_____.

Time period for this release of protected health information is from _____ to _____.

I release and agree to hold harmless Great Life Counseling Center and its trustee, officers, psychologists, other health care providers, and other employees from any and all liability associated with the release of my confidential patient information in accordance with this authorization. I understand that Great Life Counseling Center is not responsible for use or redisclosure of information by third-parties.

I understand that my records are protected under federal confidentiality (including alcohol and drug disclosure restrictions) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The conditions of this form have been explained to me and my questions have been satisfactorily answered. I understand that I am not obligated to sign this consent form, and I may revoke this authorization at any time with the exception of action already taken based on my previous approval.

_____ _____

Signature of Patient/Client Name (Print name)

_____ _____

Signature of Witness Name (Print name)

_____ _____ _____

Date of release Date release revoked Initials