Choices in Counseling
901 North Main Street – Suite B
Franklin, IN 46131
FAX: (317) 245-2367

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. *AUTHORIZATION*

I hereby authorize the use or disclosure of protected health information about me as described below:

Client Name: _____
Last First Middle

Date of Birth: _____ SS#: _____ Client ID#: _____

Address: _____

Authorize: ☐ Dorian Angebrandt, LCSW ☐ Glen Stephenson, LCSW or ☐ Other: _____

to exchange information with: _____
Company/Name Phone

_____
Address City State Zip

2. *INFORMATION TO BE USED OR DISCLOSED* (Place an **X** in each box for the information that to be disclosed.)

☐ Diagnosis
☐ Medication
☐ Assessment Information
☐ Treatment Planning Info
☐ Progress & Treatment Notes
☐ Recommendations
☐ Psychiatric Evaluation
☐ Results of Testing: _____
☐ Communicable Disease Info
☐ Reason for Termination
☐ Number of Kept Appointments
☐ Other: _____

3. *PURPOSE OR NEED FOR USE OF DISCLOSURE* (Place an **X** in each box for the reason for use or disclosure.)

☐ Collaboration with school ☐ To comply with court order ☐ For treatment of client
☐ Other: _____

4. *METHOD OF DISCLOSURE* (Place an **X** in each box for approved methods of sharing this information.)

☐ Fax ☐ Telephone ☐ Mail ☐ Email ☐ Other: _____

5. *AUTHORIZATION TERM & EXPIRATION* (Place an **X** in one box for the authorization term & expiration.)

☐ At the end of 60 days ☐ At termination of my treatment or at the end of 180 days
☐ At the following event or date: _____

6. *AUTHORIZATION RIGHTS* (Initial each box below acknowledging your understanding.)

☐ I understand that I may revoke this authorization by completing Section 7 below

☐ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to receive treatment.

☐ I understand that if I revoke this authorization at any time, it will not have any affect on actions already taken by Choices in Counseling under approval of this authorization.

☐ I understand that my records are protected by federal and state laws and cannot be disclosed without my written permission, except as noted in Choices in Counseling's Notice of Privacy Practices.

_____
Signature of Client or Representative

_____
Printed Name of Client or Representative

_____
Representatives Relationship to Client

_____
Date of Signature

_____
Witness to Authorization Signature

7. *REVOCATION OF AUTHORIZATION*
(Sign and date below to revoke this authorization.)

_____
Signature of Client or Representative

_____
Date of Signature

_____
Witness to Revocation Signature