# Private Counseling

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## RELEASE OF INFORMATION

**HIPAA Privacy Authorization Form**

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

I am completing this form to allow the use and sharing of protected health information about:

**Client Name:** _____ **Date of Birth:** _____

I **authorize** Bree Winkler LPC (therapist) **to obtain or disclose** the following information:
(check all that apply)

□ Mental health records (including diagnosis, evaluations, treatment notes, and behavioral observations)
□ Medical records □ Copy of Mental Health File (**fee required - paid in advance**) □ Billing Records
□ Communicable diseases (including HIV/AIDS) □ Alcohol/drug treatment
□ Educational documents (including test scores, IEP, SST/504, attendance, discipline, and grades)
□ Other (please specify): _____

**To/From the following person or organization**:

Name: _____ Title: _____
Address: _____
Phone Number: _____
Email Address: _____

This release shall **permit my therapist, Bree Winkler LPC, to speak directly** (verbally or in writing) **with the person/organization listed above concerning my care** (according to authorized release information noted above).

**Authorization for Release of Information**: Covering the time period from (check one below)

(date) ☐ _____ to _____ **OR** ☐ all past, present, and future information

This medical/educational information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____ _____
Signature of Client or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship to Client

___ check here if Client refused to sign authorization