People Bloom Counseling, PLLC
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AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

To: ____ [Description of providers]

I, _______________________________________ [client name], hereby request that you release my protected health information, as specified here:

____

The recipient(s) of this information is/are to be [description of recipients]:

Name(s): ____

Clinic/business name: ____

Address: ____

Phone number: ______________________ Fax number: ______________________

My initials constitute my intention to include in this authorization the following:

_____ Substance assessment and/or treatment information

_____ Psychotherapy notes (if maintained separately from my treatment record)

I understand that I may revoke this authorization in writing at any time; that the Provider will make a Revocation of Authorization form available to me; that such revocation will not be effective to the extent that substantial action may have already been taken in reliance on this authorization, including provision of health care services requiring subsequent disclosure to effect payment. I understand that the Department of Social and Health Services' certified drug and alcohol programs will honor verbal revocations upon authenticating my identity.

I understand that re-disclosure of my health information by Recipient, if unauthorized, is a potential risk. If re-disclosed, privacy laws may no longer protect the information. I understand that I do not have to sign this authorization in order to obtain treatment benefits from the Provider, except for health care services necessary to create any assessment or report contemplated by this authorization. I understand that I am entitled to a copy of any authorization I sign.

The effective date of this authorization will be the date of my signature below. If not previously revoked, this authorization will expire in 90 days or upon the following date: ________________, or upon the following event: ____________________________.

___________________________________ ____________________

Signature of Client (or Parent or Legal Guardian) Date