Compassionate
CHRISTIAN COUNSELING

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I. PATIENT IDENTIFICATION

NAME (last)	(first)	(MI)
ADDRESS		
CITY/STATE/ZIP CODE	DATE OF BIRTH	

II. _____

Personal Representative, if applicable (e.g. parent of a minor or guardian, administrator for estate)

III. The information is to be disclosed by:	**And is to be provided to:**
_____Communication only as indicated below	_____Two way communication allowed both listed partied
Name:	
Address	
Citry/State/Zip code	

IV. The information to be disclosed from the patient's health record (check appropriate box(es)).

- o Entire medical records from _____ to present
- o Only information (e.g. medical records) related to (specific event or date) specify:
- o Other(e.g. insurance coverage, billing, etc.)__specify:

The purpose or need for this disclosure is for the treatment of the above named patient. The gathered information shall not be used for any other purpose.

V. I understand that I may revoke this authorization in writing at any time by contacting my facility/provider, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

_____

(Enter Date of Termination or Expiration if different from one year after date below)

VI. SIGNATURE OF PATIENT	DATE
VII. SIGNATURE OF PERSONAL REPRESENTATIVE (IF APPLICABLE)	DATE
VIII. SIGNATURE OF WITNESS (REQUIRED BY LAW)	DATE

Consenting to this authorization of disclosure of records is voluntary and health provider(s) shall not condition treatment upon the individual's signature of such authorization for use or disclosure of health information. This information is subject to release for the purposes stated in Section IV and may not be used by the recipient for any other purpose.