Authorization for Use and/or Disclosure of Confidential and/or Protected Health Information

I, _____, (Name of client or legal guardian) hereby authorize Attentive Counseling, LLC and/or Michala Senarsky, LPC to release or exchange confidential information and/or PHI obtained prior to and during the course of my psychotherapy/counseling sessions to recipient(s) named below:

Client/Patient Information

Name: _____ DOB: ____/_____/_____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____

Recipient Information

Recipient/Company/Other Name: _____

Title: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____

This Authorization permits the release or exchange of the following information:

☐ All health information pertaining to my medical history, mental or physical condition; OR only the following types of health information (limitations on use): _____

_____

☐ I specifically authorize the release of the following information: Behavioral Health Assessment including Mental Health (Diagnosis, Treatment Plan, Prognosis, Treatment Progress, Dates of Treatment, Client/Patient Records, Summary of Treatment, Clinical Test Results, Medication, Compliance, etc.)

I authorize the release/exchange of the information described above for the following purpose(s):

☐ Patient's request ☐ Coordination of Care ☐ Other: _____

_____

I understand that I have a right to receive a copy of this Authorization. I also understand that any cancellation or modification of this Authorization must be in writing. This Authorization shall remain valid for one year from the date of signature or until: _____/_____/_____ (date).

Signature: _____ Date: ___/____/_____

If signed by other than Patient, please indicate your relationship to patient: _____