



14275 Midway Rd., Suite 260  
Addison, TX 75001

**Authorization for Release of Confidential Protected Health Information (PHI)**

Printed Full Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize Great Life Counseling Center & its representatives to obtain information from and/or release information to the person and/or agency indicated below for the purpose of treatment or \_\_\_\_\_.

Name of person and/or agency: \_\_\_\_\_

Email or Mailing address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

By checking below, I specifically authorize the release of the following information:

PSYCHOTHERAPY/COUNSELING & ASSESSMENT	PSYCHIATRIC/MEDICAL RECORDS
<input type="checkbox"/> *Summary of care	<input type="checkbox"/> *Summary of Care
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Progress notes
<input type="checkbox"/> Assessments (Diagnosis, Testing, Reports)	<input type="checkbox"/> Assessments (Diagnosis, Testing, Reports)
	<input type="checkbox"/> Psychiatric (Notes, Medications, Referrals)
	<input type="checkbox"/> Drug and alcohol information
	<input type="checkbox"/> HIV/AIDS related test results & information
<input type="checkbox"/> Information specific to: _____	<input type="checkbox"/> Information specific to: _____

\*I understand that the information to be used or disclosed if this item is checked may include information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care.

Specific conditions or limitations of the information to be released include: \_\_\_\_\_

Time period for this release of protected health information is from \_\_\_\_\_ to \_\_\_\_\_.

I release and agree to hold harmless Great Life Counseling Center and its trustee, officers, psychologists, other health care providers, and other employees from any and all liability associated with the release of my confidential patient information in accordance with this authorization. I understand that Great Life Counseling Center is not responsible for use or redisclosure of information by third-parties.

I understand that my records are protected under federal confidentiality (including alcohol and drug disclosure restrictions) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The conditions of this form have been explained to me and my questions have been satisfactorily answered. I understand that I am not obligated to sign this consent form, and I may revoke this authorization at any time with the exception of action already taken based on my previous approval.

\_\_\_\_\_  
Signature of Patient/Client

\_\_\_\_\_  
Name (Print name)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Name (Print name)

\_\_\_\_\_  
Date of release

\_\_\_\_\_  
Date release revoked

\_\_\_\_\_  
Initials