RESTORATION COUNSELING

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AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Date: _____ Client Name: _____ DOB:_____

To: _____

Address:_____

Phone: _____

I _____, hereby authorize **Angela Landry, LMFT** at 7003 Chadwick Dr, Suite 335, Brentwood, TN 37027 to:

_____OBTAIN _____RELEASE _____COMMUNICATE WITH

the following protected health information concerning professional services received by myself or my minor child or legal charge. It is further understood that this authorization is subject to revocation at any time in writing, and unless otherwise specified hereinafter, it automatically expires one year from the signature date.

Specific Information to be Disclosed (**client must initial each item to be released/obtained**)

___Psychological Evaluations

___Diagnostic Information

___Treatment Summaries

___Medications

___Statement of Progress

___Psychotherapy Notes

___Discharge Summary

___Recommendations for Therapy

___Other: _____

The information is needed for the purpose of:

____Continued Treatment

____Utilization Review

____Consultation Purposes

____Consideration of Payment

____Other: _____

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my health information and no longer protected by the HIPAA Privacy Rule. I understand all of the aforementioned, and with informed consent and of my own free will, authorize disclosure of protected health information.

Please forward any requested information to:
Angela Landry, LMFT
7003 Chadwick Dr, Suite 335
Brentwood, TN 37027

Signed: _____ Date: _____

Witness: _____ Date: _____

Guardian of minor: _____ Date: _____