Luminous COUNSELING

RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ , am a client of Sarah Shine and my information is below:
CLIENT NAME

- -
MY SOCIAL SECURITY NUMBER

/ /
MY DATE OF BIRTH

( ) -
MY TELEPHONE NUMBER

MY EMAIL ADDRESS

1. I hereby authorize the release of my confidential health information to:

RECIPIENT AGENCY/PERSON

NAME OF SPECIFIC AGENCY AND/OR PERSON

ADDRESS

PHONE

INFORMATION TO BE DISCLOSED

- ☐ My entire clincial record
- ☐ A letter of confirmation for treatment
- ☐ A billing summary
- ☐ Other: _____

PURPOSE OF DISCLOSURE

- ☐ Speak to a third party (i.e., another provider, attorney, family member, primary care provider, school, etc.) specifically
- ☐ Send a copy of all or part of my clinical record to a third party specifically
- ☐ Other: _____

EXPIRATION DATE

- ☐ End of treatment
- ☐ Specific Date: _____

IMPORTANT INFORMATION

This authorization is voluntary and can be revoked at any time, except to the extent that action has already been taken in reliance on it. The information disclosed may no longer be protected by federal privacy regulations once it is disclosed.

If the recipient is not a healthcare provider or health plan covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations once it is disclosed.

CLIENT SIGNATURE

/ /
CURRENT DATE