GENEE FRANCIS, LPC-S, NCC

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AUTHORIZATION TO RELEASE INFORMATION FORM

TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I,____ _____ /_____,
(Full Legal Name) **(Date of Birth)**

hereby give my informed consent and authorize Genee Francis, LPC-S, NCC to talk with and/or release protected health information

regarding treatment concerning _____ to the following individual(s):
(Patient)

Name

Organization Name (If Different)

Address

Phone

I release information to be disclosed to include copies of: _____Session Notes _____Entire Record _____Other_____

The information will be disclosed for the following purposes: _____

I understand that my records are protected under Federal Regulation (CFR), and under the general laws of my state and cannot be disclosed without written consent, except as specifically stated by law.

I understand that if the person or entity that receives that information is not a healthcare provider or health plan covered by HIPAA privacy regulations, the information may be redisclosed and no longer protected by those regulations.

This authorization expires one year from the date I sign this form. I understand that I may revoke my authorization to release information at any time in writing and such revocation will be effective on the date of receipt of my revocation.

In consideration of this consent, I hereby release the above parties from any legal liability with the release of this information.

_____ _____

Signature of Patient or Guardian **Date**