MORGAN
Counseling
SERVICES LLC

AUTHORIZATION FOR USE AND DISCOLSURE OF PROTECTED HEALTH INFORMATION

Patient Name____ Date of Birth_____________________

Address____ SS#_____________________

Home Phone_______________________ Work/Cell Phone_______________________

I, the undersigned patient or legal guardian, hereby authorize ____ verbal and/or ___written information to be released by:

____

Name of Releasing Provider

____

Address Phone

TO:

____

Name of Provider/Hospital/Third Party Phone

____

Address Fax

Information to be released:

___ Progress Notes
___ Treatment Planning
___ Psychiatric Evaluation
___ Psychological Testing
___ Discharge & Aftercare Plan
___ Psychosocial
___ Medication Record
___Other___________________________

Release of information for the following purpose(s):

____Treatment/Consultation ___Patient Request ___Billing/Claims ___Attorney
___Other____

- I understand that this authorization is voluntary and that treatment by the counselors at Morgan Counseling Services cannot be conditioned on signing of this authorization.
- I understand there may be a charge, payable in advance, for the copying and conveyance of records released.
- I understand that this authorization can be withdrawn by me, in writing, at any time. I cannot, however, take exception to actions that have taken place before I withdrew my consent.
- I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected. Morgan Counseling Services is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that the information that is being released is from records whose confidentiality is protected by state and federal law.

____ _________________________________

Patient/Legal Guardian Date

____ _________________________________

Witness & Title Date
Expiration Date: 60 days after signature