Lacamas Counseling
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LACAMAS COUNSELING

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
(RELEASE OF INFORMATION)

Client Name_____ Date of Birth_____

For the purpose of coordinating care, I authorize **Lacamas Counseling** to use and disclose my Protected Health Information (PHI) to:

Person/Agency: _____
Phone: _____
Address: _____
_____
Fax: _____
Email: _____

Information authorized to be disclosed:

- ☐ All pertinent and relevant information including assessment, diagnosis, treatment plan, progress notes, finances/insurance, appointments, scheduling, and clinical insights
- ☐ Scheduling and appointments
- ☐ Finances, insurance, and billing
- ☐ Emergency Contact
- ☐ Other (please specify):
  _____

Please initial:

_____ I understand that the information used or disclosed may be subject to re-disclosure by the person receiving the information and would no longer be protected by federal privacy regulations.

_____ I understand that I may revoke this authorization at any time by notifying Lacamas Counseling in writing of my desire to revoke it.

_____ I also authorize CONCURRENT DISCLOSURE of all pertinent and relevant PHI from the other designated party.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my Health Information. By my signature below, I hereby knowingly and voluntarily authorize the Lacamas Counseling to use or disclose my health information in the manner described above.

_____ _____
Client Signature Date

_____ _____
Provider Date