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"FOSTERING CONNECTION WITH YOURSELF AND THE ONE'S YOU LOVE."

Authorization for Release or Exchange of Information

Client Name: _____ Date of Birth: _____

Phone Number: _____ Address: _____

_____

I hereby authorize Alexis Evans, LMFT to request information from and/or release Confidential Protected Health Information to:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____ Email: _____

Check one of the following:

- ☐ Exchange or release all information related to the coordination of care and treatment planning.
- ☐ Limit the release or exchange of information to:

_____

My right to confidentiality has been explained to me or I have reviewed HIPAA rules and I understand the information to be released, the purpose of release, and the statutes and regulations protecting my confidentiality. This authorization is only for the limited purpose of obtaining for up to one year, discussing my case with these individuals or agencies for the specific purpos of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information. I have the right to revoke this authorization at any time by sending written notice to Alexis Evans, LMFT. However, revocation will not be effective to the extent that action based on the consent has already taken place or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Further, I understand that information used or disclosed pursuant to the authorization is beyond the control of Alexis Evans, LMFT, and consequently may be subjected to redisclosure by the recipient and no longer protected by HIPAA.

_____ _____

Card Holder Signature Date