1440 Campbell Lane, Suite 600
Bowling Green, KY 42104
P:270-715-1178 F:207-715-1189

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

Client Name	Date of Birth	Name of Provider
Individual/Professional/Agency/Physician		Phone number
Street Address	City	State/Zip

Information to be released

Treatment plan & social history _____	Psychological evaluation(s)_____	Other _____
Summary of treatment _____	Billing records _____	_____
Complete clinical records _____	Consultation(s) _____	

Purpose of Release

At the request of the undersigned _____	Coordinate treatment _____	Other _____

I understand that I can revoke or cancel this authorization at any time by sending a letter to Journey Through Counseling, LLC. If I revoke my authorization, it will prevent any release after the date it is revoked but can not undo what information my already have been released.

I understand and agree that this Authorization will be valid and in effect until date or 60 days after end of treatment, or event _____, unless otherwise revoked.

I understand that I may inspect and have a copy of the health information described in this authorization.

I acknowledge that I was offered a copy of the completed from.

Signature of client or personal representative	Date
Printed name of client of personal representative	Relationship to client