Philip J Fauerbach, LMHC

Licensed Mental Health Counselor

License#: MH3399

AUTHORIZATION AND CONSENT FOR RELEASE OF PRIVLEDGED INFORMATION

NAME: _____ **DATE OF BIRTH**: _____ **SS#**: _____

This form when completed and signed authorizes the release of protected and or confidential psychological information from my clinical record to the person or agencies designated. It is understood that this form does not constitute a general release, and that by checking off or specifying information below I am agreeing to an informed release of specific sensitive and confidential information. It is also understood and agreed that Philip J Fauerbach is not responsible for and cannot control further release by the agencies or individuals this information is sent to.

I authorize_____

to release the following individually checked items in their entirety or additional information as indicated below:

___Intake summary

___Discharge/Treatment Summary

___Diagnostic Information

___Progress Notes

___Other (specify)_____

___Letters/Updates to referral source or other treating provider

___Treatment Plans

___Records of Attendance

___Treatment Recommendations

For the specific purpose of: _____

This information may be released by sending copies, facsimile, by phone, or in person and should only be released to: **Philip J Fauerbach, LMHC.** This consent is subject to revocation at any time except to the extent that Philip J Fauerbach or his agents have already taken action in reliance on it. I hereby release Philip J Fauerbach and his agents from any liability which may arise as a result of the use of any information contained in the records released. This authorization will expire 180 days from the date signed. I acknowledge that I have read this authorization, fully understand it contents, and have voluntarily signed it on this date.

A COPY OF THIS RELEASE SHALL BE AS VALID AS THE ORIGINAL

I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information, viewed by person unknown, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules.

Name of client: _____Date: _____

Signature of Client/Authorized Representative:_____Relationship to Client:_____

ATTENTION TO AGENCIES AND/OR INDIVIDUALS TO WHOM THIS INFORMATION IS DISCLOSED:

Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited unless the participant provides specific written consent for subsequent disclosure of this information. These records may be protected by Federal Regulation (42 CFR, Part 2). Federal rules restrict any use of the information to criminally investigate or prosecute alcohol/drug abuse participants.

If you have received this information in error please contact our office as soon as possible to arrange for the return of the received material. The information you have been seen may be protected from re-disclosure without informed signed consent from the individual or agency to which it pertains. Do not re-disclose this confidential information without signed informed consent or as otherwise allowed by law.

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