ATLAS Counseling, LLC

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Name of Client _____ Date of Birth _____

I, _____, hereby authorize Atlas Counseling, LLC, Shannon Seibel, LPCC (hereinafter "Provider") to disclose/exchange mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to provider's assessment and clinical recommendations, of the client listed above to:

Name _____

Phone _____

Email _____

Address _____

City State Zip _____

Delivery Method:

- ☐ Secure Email (will be sent to the above email address unless otherwise specified)
- ☐ USB or electronic device
- ☐ Fax
- ☐ Paper (will be sent via USPS mail unless dropped off/picked up)
- ☐ Other (specify) _____

I am requesting this disclosure of information and records for the following purpose:

- ☐ At the request of: _____
- ☐ Other: _____

The specific uses and limitations of the types of health information to be released are as follows:

(Check all that apply)

- ☐ Treatment Coordination
- ☐ Treatment Planning
- ☐ Diagnostic Assessments or Evaluations
- ☐ Medical history and evaluation(s)
- ☐ Developmental and/or social history

☐ Educational records

☐ Progress notes, and treatment or closing summary

☐ Written correspondence

☐ Other _____

Disclosures:

Such disclosures shall be limited to the following specific types of information:

☐ Psychiatric diagnosis(es)

☐ Dates of Treatment

☐ Treatment Summary

☐ Initial Treatment Plan

☐ Full Treatment Record

☐ Other: _____

The above information will be used for the following purposes:

☐ Planning appropriate treatment or program

☐ Continuing appropriate treatment or program

☐ Determining eligibility for benefits or program

☐ Case review

☐ Updating files

☐ Insurance claim or application

☐ Disability Determination

☐ Personal

☐ Other _____

This authorization shall remain valid from _____ until: _____ (not to exceed one year).

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and not a condition for treatment, payment, enrollment or eligibility for benefits, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been

informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature of Client _____

Date _____

Signature of Legal Guardian, Relationship to Client _____

Date _____

Signature of Provider_____

Date _____