ST. Raphael Counseling, LLC
1115 Grant Street, Suite 305 ● Denver, CO ● 80203● 720.675.7796

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME (please print) _____ DOB_____

I, the above mentioned, hereby authorize St. Raphael Counseling, LLC to:
_____ provide information to _____ receive information from

FACILITY/PERSON: _____ Phone _____

_____
Address City State Zip

INFORMATION TO BE PROVIDED/RECEIVED:

_____ Treatment Plan	_____ Social History	_____ Psychological Evaluation
_____ Termination Summary	_____ Academic Records	_____ Psychiatric Evaluation

Other (specify) _____

THIS INFORMATION IS TO BE USED FOR THE PURPOSE OF:

_____ Follow-up	_____ Education Program	_____ Evaluation and/or Treatment

Other (specify) _____

This authorization to release information will be effective for six (6) months. If a shorter time period is desired, please indicate the date on which this authorization will become null and void (please specify)_____

- I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to St. Raphael Counseling, LLC office address. However, my revocation will not be effective to the extent that St. Raphael Counseling, LLC has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my psychotherapist/counselor generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
- I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.
- I hereby release St. Raphael Counseling, LLC and all its Employees from all legal liability that might arise from the release of the information requested.

_____ _____
Client Date

_____ _____
Parent/Legal Guardian (relationship) Date

_____ _____
Witness Date

_____ _____
Counselor Date