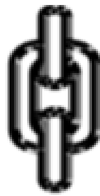

Chane Reaction LLC

Counseling Services

Linking You To Resources For A Better Tomorrow

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(The execution of this form does not authorize the release of information other than that specifically described below)

TO: RELEASE TO:

___________________________________ ____

___________________________________ ____

Client Name DOB

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency, or individual named on this request. I understand that the information to be released includes the following information:

INFORMATION REQUESTED:

____Copy of complete medical records

_____ Copy of clinical notes/documentation conditions

____Other (e.g. diagnosis, hospitalizations)

____

DATES COVERED:

____All treatment rendered in this office or by this doctor/therapist

____Limited to treatment dates for

____

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

_______Transfer of records

______Second Opinion

Other:____

____

____

AUTHORIZATION*: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on(date supplied by the patient); or iff revoked in writing by the patient; or_180 days from the date hereof; or under the following conditions:*

____

OTHER CONDITIONS: A copy of this authorization or my signature thereon: _x_ may not be used with the same effectiveness as an original.

PATIENT NAME (print)

PATIENT SIGNATURE