Lindsay Martin, PhD, LPC, NCC

Licensed Professional Counselor

lindsay@drlindsaymartin.com www.drlindsaymartin.com

Authorization for Use or Disclosure of Protected Health Information

Client Information

First Name_____ Last Name _____ Middle Name _____

DOB: ___/___/_____

Recipient Information

I, _____, do hereby authorize **Lindsay Martin, PhD, LPC, NCC** to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical/clinical information:

_____

Phone Number: _____ **Email Address:** _____

Address: _____

Date of Authorization: ___/___/_____ Authorization to expire on ___/___/_____

Information to be released (Check all that apply)

___ Intake assessment ___ Progress in treatment ___ Dates in treatment

___ Treatment plan ___ Emergency Contact Only

Purpose of Information Release (Check all that apply)

___ Further mental health care ___ Insurance request ___ Legal investigation

___ Applying for insurance ___Coordination of care ___ Request of individual

___Other (specify): _____

Authorization and Signature

Disclosure and/or exchange of the protected health and account information as authorized above may include communication by phone, fax or mail. This disclosure and/or exchange may include information regarding drug, alcohol or sexual abuse, psychological or psychiatric impairments, HIV and/or AIDS, or other physical conditions. If the authorized individual or entity that receives or releases this information is not a health insurance plan or health care provider covered by federal privacy regulations (HIPAA), the released information may be re-disclosed at will by the recipient or sender without the consent of the patient or guarantor and may no longer be protected by federal or state law.

If I refuse to sign this form, I understand that it will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or eligibility for health benefits.

NOTE: This consent expires one year from signing; however, it may be revoked at any time IN WRITING, except to the extent that any action has already been taken prior to revocation. I have read and understand the above statements and I consent to the release of the protected health and account information as indicated above. I also understand that there may be costs incurred with this request. Any such costs will be in compliance with state copying laws.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

For Minor Children or Those Under Guardianship

Parent/Guardian Print Name: _____

_____ _____

Signature of Parent/Guardian Date

_____ _____

Therapist Signature Date