Authorization for Release of Information

Name: _____ **Date of Birth:**_____

Address: _____ **City, State, Zip:**_____

_____

Phone Number: _____**Email:**_____

☐ **I authorize Rob Reinhardt, LPC, PA to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)/ Email

AND/OR

☐ **I authorize Rob Reinhardt, LPC, PA to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)/ Email

PURPOSE OF THIS REQUEST: (check one) ☐ **Healthcare** ☐ **Insurance Coverage** ☐ **Personal** ☐ **Other**

TYPE OF RECORDS AUTHORIZED: ☐**Psychiatric/Psychological/Counseling Evaluation and/orTreatment**
☐**Drug/Alcohol Evaluation and/orTreatment**

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **Assessments** ☐**Progress Notes** ☐**Laboratory Test Results:** _____

☐ **Diagnostic Impression** ☐**Discharge Summary** ☐**Treatment Plans**

☐ **Treatment Summary**

☐ **Other: (**please describe)_____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**

☐When the requested information has been sent/received.
☐90 days from this date. ☐Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire:
☐When I am no longer receiving services from Rob Reinhardt, LPC, PA
☐One year from this date. ☐Other_____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.

I may cancel this authorization at any time by submitting a ***written*** request to Rob Reinhardt, LPC, PA, except where a disclosure has already been made in reliance on my prior authorization.

- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of Client or Representative: _____ Date:_____

Relationship to Client (*if requester is not the client)*: ☐Parent ☐Legal Guardian ☐Other_____