Authorization for Disclosing or Requesting Protected Health Information

Client's Name:	DOB:
Address:	Phone:

Lifebridge Counseling, LLC is hereby authorized to (check all that apply):

☐ Disclose & Send Information	☐ Request & Receive Information	☐ Discuss Information With
Person/Agency Name:	Address:	
Phone:	Fax:	

Specify Description of Information:

☐ Intake/Assessment	☐ Participation and Attendance	☐ Diagnosis
☐ Treatment Progress	☐ Other:	☐ Other:

Specify Purpose for Request:

☐ Service Coordination or Discharge Planning	☐ Insurance or Legal Requests	☐ Other:

This authorization is effective beginning ___/___/___ and will be expire in one year.

As the person signing this authorization, I understand I am giving permission to Lifebridge Counseling, LLC to use, disclose, and/or request confidential health care information and that the authorization is effective for one year. I also understand I have the right to revoke or edit this authorization at any time by providing written notice to my provider at Lifebridge Counseling, LLC.

____ ____________________

Printed Name of Client or Legal Guardian Date

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Signature of Client or Legal Guardian