MORNINGSTAR COUNSELING, LLC
AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

☐ **I hereby authorize Morning Star Counseling to RELEASE my protected health information (PHI) to:**

_____

☐ **I hereby authorize Morning Star Counseling to OBTAIN my protected health information (PHI) from:**

_____

Disclosure Scope for PHI Release:

The Information released includes, but according to Federal Regulation 42 CRF 2.35(a), 2.31 & 2.35(b) & (c), is limited to the following:

_____Whether the client is or is not in treatment.

_____Prognosis of the client.

_____The nature of the project or facility.

_____A brief description of the progress of the client.

_____A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

This Information is needed for the following purposes:

_____To provide my insurance company, hospital or health plan with the necessary information to obtain my benefits for treatment and/or meet agreed upon goals

_____To notify my Probation/Parole Office, Judge or other officer regarding my participation in drug and alcohol treatment and assist them in making informed decisions concerning my legal matters.

_____Other

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released by *Insert company name*, Inc. without my written consent. I understand that this authorization will remain in effect for:

☐ The period necessary to complete all transactions on accounts related to services provided to me.
☐ One (1) year
☐ Other:_____

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/custodian of this child.

_____ _____

Signature of Client/Legal Guardian or Legally Authorized Representative *Date*

_____ _____

Witness *Date*