2690 Billingsley Rd., Columbus OH 43235
1434 N. Court St. , Circleville OH 43113
18077 St. Rt. 31, Marysville OH 43040
1528 London Groveport Rd. Grove City OH 43123

Authorization to Release Information

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows Arbor Counseling, LLC to release and/or exchange your protected health information. You can revoke this authorization at any time by submitting a request in writing to the agency. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Section A. Member Information: (individual whose information will be released)

Name: (First, Middle, Last)	**Date of Birth:**
Address: (including zip code)	**Phone:**

Section B. Therapist and Agency: (organization that will release and/or receive your information)

I authorize _____ and Arbor Counseling, LLC to release and/or exchange my protected health information as described below.

Section C. Third Party: (person or organization that will receive and/or release your information)

Person's Name or Organization:	Relationship:	**Phone:**
Address:		**Fax:**

Section D. Description of the Information to be Released: (what type of information will be released)

☐ **All information necessary for coordination of care**	☐ **Initial Intake/Discharge Summary**
☐ **Psychological Testing Reports**	☐ **Psychiatric Assessment**
☐ **Other:**	

Section E. Purpose of Release: (why this information is being released)

☐ **Coordination of care**	☐ **Per My Request**
☐ **Other:**	

Section F. Expiration: (when this authorization will end)

This authorization will expire (Check ONLY ONE box):

☐ **When I revoke this authorization** ☐ **Conclusion of therapy**

☐ **Upon the following date, event or condition:**_____

Note: You have the right to revoke this authorization, in writing, at any time by sending such written information to our office. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. By signing you also acknowledge understanding that information used or disclosed to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Client Signature: By signing below, I authorize the release of my protected health information as described above.

Signature	Date
Printed Name	