SouthernMED COUNSELING

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This Authorization permits the staff of SouthernMED Counseling to use or disclose information for purposes of care in your treatment. You have the right to revoke this Authorization by providing written notice of revocation to the address listed at the bottom of this document. SouthernMED Counseling cannot require you to sign this Authorization as a condition to the provision of services. Once we disclose this information, we have no control over how it may be used by the recipient.

Authorization:
I hereby authorize **SouthernMED Counseling**, by any acceptable means, including phone, fax, mail, or electronic transmission, to use or disclose my Protected Health Information described as follows (check all that apply).

☐ Entire record
☐ Discharge Summary
☐ Evaluation Results/Summaries
☐ Correspondence with others involved in your care
☐ Other_____
☐ Treatment Plans/Updates
☐ Recommendations
☐ Progress Summaries
☐ Appointment/billing records
☐ Diagnoses
☐ Intake Paperwork
☐ Assessments

To: the following persons or class of persons (include name, address and telephone number):
_____
_____
_____
_____

Purpose:_____

This Authorization shall expire on _____, 20__ __, which is not more than one year after its effective date, unless it is revoked prior to the expiration date.

_____ _____
Print Patient Name Date of Birth

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date

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