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| **PURPOSE OF RELEASE: X** Ongoing Communication ­ X Copy of Record \_\_Legal or Insurance Review X Authorized Representative’s Request Other**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **RELEASE FROM** Facility/Practice Name**: Christ Centered Community Counseling, PLLC** Telephone #: 704-537-7775Facility/Practice Address: 2330 Morton Street, Charlotte, NC 28208 Fax #: 704-705-1546 |
| **DATEDS OF SERVICE OR TIME FRAME:** The facility/practice/individual listed above is authorized to release the requested health information listed below for the following: date(s) of service, range of time or events(s):**From: (MM/DD/YY) 11/16/2019 To: 11/16/2020**This authorization will expire when the requested health information (as noted below), for the requested date(s) of service, range of time or event(s) (as noted above), is released to the recipient named in this document and the purpose of the release is satisfied. |
| **CHECK THE INFORMATION TO BE RELEASED:** (Please See Above) *I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).* |
| **NAME OF CLIENTWHOSE INFORMATION IS TO BE RELEASED:**Client Name**:** Client Email: Client Phone: Date of Birth:  |
| **RELEASE TO:** This information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below:**Name Telephone/Fax # Organization** |
| **CLIENT’S RIGHTS AND SIGNATURE:*** I understand that I have a right to revoke this authorization at any time by notifying Jarris Bell in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.
* I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
* I understand that I may request to inspect or obtain a copy of the information to be used or disclosed per Jarris Bell Notice of Privacy Practices/Policy.
* I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third party can receive my health information, such as an employer for a return to work evaluation, an insurance company for eligibility, or a research project in which I am participating.
* If the Client is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

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| **MINOR’S SIGNATURE:** Please note, if the minor consents (no guardian is present to consent) for their own treatment for pregnancy, venereal disease, or emotional disturbance, the minor must sign this authorization. When the Client is a minor being treated for substance abuse, the minor must sign this authorization, regardless of whom consented for treatment.**NAME OF MINOR**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**SIGNATURE OF MINOR**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE**: \_\_\_\_\_­­­\_\_\_\_\_\_\_  |