AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent and authorize Valerie Peckham, LCP, and Acme Counseling and Consulting Services to:

__ obtain __release __ exchange oral and written communication (including through email and text)

with the following person/organization:

Name/Provider:_____ _____

Relationship/Organization:_____ _____

Address:_____ _____

Phone/Email:_____

pertaining to the protected health information checked below belonging to:

Client Name_____ DOB:_____ _____

__ Presence in treatment, including scheduling
__ Intake evaluation, including substance use
__ Treatment Plan
__ Presentation, Diagnosis, description of progress, and prognosis
__ Psychological tests
__ Progress notes
__ Legal information
__ Evaluations
__ Substance abuse information
__ Billing/Financial
__ Medical history and physical examinations
__ Mediation Record
__ Physician's orders
__ Lab
__ Medical discharge summary
__ Crisis screening report
__ HIV/AIDS status
__ other:

I understand that the release of this information is to permit my treating physician, other health care practitioners, and other specified parties to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance herein. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient(s) only. Additional information may be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

Signature/relationship:_____ Date:_____