Patient's Name: _____ Date of Birth: _____

RELEASE OF INFORMATION

I, _____ (patient/patient's guardian) authorize a mutual exchange of information about the above mentioned patient between the therapist, Sammi L. Siegel, Ph.D., LMHC, of Siegel Counseling Services, and the following recipient:

Name: _____

Address: _____

_____

Phone: _____

This information includes and is not limited to, medical records, academic records, counseling information and other pertinent information used solely for the facilitation of services rendered to the above-named individual.

If we are requesting this authorization from you for your own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- We may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization; and
- We must provide you with a copy of this authorization.

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.
Unless revoked earlier or otherwise indicated, this authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Signed: _____ Date: _____
(Patient or Patient's Representative)
Representative's relationship to Patient: _____
_____