Abiding Hope Counseling

WWW.AHCounseling.com **719-362-0132**

Authorization for Disclosure of Confidential Information

I understand Abiding Hope Counseling is authorized by me to use or disclose my Protected Health Information (PHI) for the purpose of treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that the provider has the right to refuse to treat me if I refuse to sign this consent or if at any time I choose to revoke this consent.

I specifically authorize, Abiding Hope Institute of Christian Counseling to disclose my PHI as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth. The patient agrees that a photocopy of this authorization may be considered valid. I fully understand and accept the terms of this authorization.

Patient Name:_____Date of Birth:_____

Address:_____

Abiding Hope Institute of Christian Counseling is authorized to release the following information to:

Name (Dr./Insurance Company/other professional):_____

Address:_____

Phone:_____Fax (if known):_____

Please check all items, which can be released:

_____Medical Records _____Care Plan

_____Progress Notes _____Therapy Reports_____Other (be specific)

This authorization covers patient care given for one year from the date below for the purpose of:

_____Medical Care _____Attorney

_____Insurance _____Other (be specific)

_____I hereby do **NOT** authorize you to provide or receive any pertinent information regarding my care.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient Name of Representative/Authority to Sign