



**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

|                     |             |                |
|---------------------|-------------|----------------|
| Client's Last Name: | First:      | Date of birth: |
| Street Address:     | Cell Phone: |                |
| City:               | State:      | Zip Code:      |

**I hereby give Richmond Creative Counseling, LLC authorization to (specify):**

|  |   |  |
|--|---|--|
| <input type="checkbox"/> Release information to: | <input type="checkbox"/> Obtain information from: | <input type="checkbox"/> Discuss information with: |
| Company/ Provider/ Person Name:                  |   |  |
| Address:   |   |  |
| Phone:   | Fax (required):                                   |  |

Covering the period(s) of treatment from \_\_\_\_\_ to \_\_\_\_\_; or ALL Dates

**Information Requested (check all that apply):**

- Records- Date(s) specified above
- Lab Work
- Records DO NOT need to be sent
- Other (specify): \_\_\_\_\_

**For the purposes of:**

- Coordination of care with another provider
- Moving/ Transferring Care
- Insurance/ Disability/ Legal

*I understand if records are being requested, I must allow a two week processing period.  
 I understand this authorization will expire in ONE YEAR unless otherwise indicated in writing.  
 I understand I may revoke or edit this authorization at any time by providing written notification to my provider at Richmond Creative Counseling, LLC*

\_\_\_\_\_  
 Printed name of Patient or Legal Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Patient or Legal Guardian