RICHMOND CREATIVE COUNSELING

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):

☐ Release information to:	☐ Obtain information from:	☐ 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