Link Relationship Counseling LLC

Gina R. Young, MA, BCPCC, LPC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name of Client (First, MI, Last):
Address (Include City, State, Zip):
Birthdate:

The above party authorizes Link Relationship Counseling LLC, Gina R. Young, LPC to use and disclose Protected Health Information to:

Name of Person or Organization:	**E-mail:**
Address (Include City, State, Zip)**:**	
Phone Number:	**Fax Number:**

Check the type of information that may be disclosed:

	Psychiatric evaluation
	Psychological evaluation
	Medical information
	Alcohol and/or drug use
	Verbal communication
	Assessment and psychotherapy notes
	Information to bill third party for services
	Other: _____

Check the purpose of disclosing this information:

	To facilitate counseling/therapy
	To facilitate educational planning
	To facilitate psychological evaluation
	To obtain medical health assessment
	To obtain payment by third party/insurance
	Legal investigation
	Coordinate care with physician
	Other:_____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, the health information disclosed as a result of this authorization may no longer be protected by federal privacy standards and my health information may be re-disclosed by such entities without obtaining my authorization. I may rescind this authorization in writing at any time. Information already released as a result of this authorization cannot be revoked. I have the right to inspect and receive a copy of the records to be disclosed and a copy of the authorization. I have the right to refuse to sign the authorization. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on my signing this authorization.

Expiration Date (please check one):

_____Authorization expires once all services with Gina R. Young, LPC are complete and file is closed.

_____Authorization expires after payment by third party payor is complete.

_____Authorization expires _____ month(s) from the date I sign this authorization.

_____Other: _____

I have had the opportunity to review and understand the content of this authorization form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Client's Signature | Print Name | Date

_____ _____ _____

Signature of Client's Legal Representative | Print Name | Relationship to Client