



Authorization for Release of Personal Health Information and Medical Records

This release of information will allow another person to access your medical information. (This includes health information, which is any information that relates to your past, present, or future physical or mental health or medical condition. I authorize the disclosure of my personal health information as described below. I understand that this authorization is voluntary.

I hereby give permission to obtain my Personal Health Information, along with two-way communication with the source of the information:

Name: _____ Phone: _____

Address: _____ City: _____ State & Zip: _____

Verbal and written communication of ALL records/pertinent information needed for the purpose of rehabilitation treatment services and the complete continuation of care for the consumer.

Right to revoke: I may revoke this authorization at any time except to the extent that action has been taken. If I do not revoke it, this authorization will expire one year after the date on which it was signed. To revoke this authorization, I will make a written request to cancel consent with my therapist and/or Earl Ridgell Counseling.

Client Name: _____ Phone: _____

Address: _____ City: _____ State & Zip: _____

I, _____ have had the full opportunity to read the contents of this authorization and I confirm that the contents are consistent with my direction to the person named above. I understand that, by signing this form, I am confirming my authorization that the above named person(s) or organization may use and/or disclose nonpublic personal health information described in this form. I have read all of the above and have had an opportunity to ask questions. All information exchange will be between the parties listed above and Earl Ridgell Counseling. Contact the office at 410-999-4886 with any questions.

Client or Guardian Signature Date

If a personal representative, on the behalf of this individual signs this authorization, complete the following:

Representative Signature Relationship to Client Date