Counseling Strategies, LLC

Authorization for Release/Exchange of Information

I authorize _____ (Person/Organization) to ☐ disclose / ☐ obtain my or my child's protected health information ☐ to / ☐ from Amanda J. Moeller, M.Ed., LPC at Counseling Strategies, LLC as described below:

Client Name _____ Birth Date _____

Parent/Guardian Name (if applicable) _____

☐ Appointment Information
☐ Assesment
☐ Diagnosis
☐ Psychosocial Evaluation
☐ Psychological Evaluation
☐ Psychiatric Evaluation
☐ Treatement Plan or Summary
☐ Current Treatment Update
☐ Coordination of Treatment Services
☐ Progress in Treatment
☐ Presence/Participation in Treatment
☐ Demographic Information
☐ Medical Information
☐ Medication Management Information
☐ Educational Information
☐ Social History
☐ Other _____

Purpose

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify: _____

Expiration and Revocation

This authorization will expire one year from the signed date below, unless revoked prior. I understand that I have a right to revoke this authorization, ***in writing***, at any time. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure is to be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbal (phone or in person), in paper format, or electronically.

Protected Health Information (PHI)

I understand that my PHI records are confidential. I understand that by signing this authorization, I am allowing the release of my PHI. PHI is individually identifiable health information, including demographic information, collected from me or created/received by a health care provider, a health plan, my employer, or a health care clearinghouse that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me. In addition, it may include information relationg to sexually transmitted diseases, other communicable diseases, and/or alcohol/drug abuse.

I understand that if my PHI is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my PHI described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that authorizing the disclosure of my PHI is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. If I have any questions about disclosure I can contact Amanda J. Moeller, M.Ed., LPC.

Amanda J. Moeller, M.Ed., LPC
amoeller@counselingstrategiesllc.com
Phone: 314.292.9211

COUNSELING STRATEGIES, LLC

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

AUTHORIZATION

By my signature below, I hereby acknowleddge that I have read, understand, and **authorize** to release/exchange my information to the person/organization listed above. I understand that I have the right to receive a copy of this authorization.

CLIENT NAME _____ BIRTH DATE _____

_____ _____

CLIENT OR PARENT/LEGAL GUARDIAN SIGNATURE DATE

_____ _____

AMANDA J. MOELLER, M.ED., LPC DATE

REVOCATION

By my signature below, I hereby **revoke** my authorization to release/exchange my information to the person/organization listed above. This revocation effectively makes null and void any permission for disclosure of my information expressly given by the above authorization previously. I understand that any actions based on this authorization, prior to revocation, will not be affected. A copy of this revocation must be presented to Amanda J. Moeller, M.Ed., LPC.

CLIENT NAME _____ BIRTH DATE _____

_____ _____

CLIENT OR PARENT/LEGAL GUARDIAN SIGNATURE DATE

_____ _____

AMANDA J. MOELLER, M.ED., LPC DATE

AMANDA J. MOELLER, M.ED., LPC
amoeller@counselingstrategiesllc.com PHONE: 314.292.9211