ENVISION
COUNSELING AND CONSULTING

Authorization for the Use and Disclosure of Health Information

Client Name: _____ Date of Birth: ____/_____/_____

I hereby authorize and request the Employed Licensed Clinical Professional Counselors and Licensed Clinical Social Workers of Envision Counseling and Consulting to **release**_____(***Initial***) and/or **obtain**_____(***Initial***) confidential professional information, including personal, psychological, psychiatric, and/or medical records and opinions, resulting from my contacts with them, for the purpose of coordinating or providing mental health care from, or to, the following named parties:

Insurance Company: _____

School: _____

Physician: _____

Other: _____

Other: _____

Please specify information to be requested here, or initial ALL to indicate full release of information within the scope of treatment needs:

_____

_____

ALL _____ (***Initial***)

I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing any of the above-noted individuals in writing. I further understand that revocation of this consent is effective upon the date of receipt. In certain situations, if consent is not received, treatment may not be possible. In addition, I understand that there is a potential for re-disclosure of this information by the recipient. If this re-disclosure were to occur, it is possible that the information will no longer be protected by Federal Privacy Acts. Furthermore, the above consent will expire at one year from the date of the signatures below. In consideration of this consent, I hereby release the above parties from any and all liability arising therefrom. A copy of this form available upon request.

Signature of Client _____ **Date:** _____
(or Authorized Representative)

Relationship of "Authorized Representative":_____

Signature of Witness: _____ **Date**: _____

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