Willow Creek Counseling Center, LLC 859-554-0740 1050 Chinoe Rd. Suite 203 Lexington, KY 40502

Authorization to Use and Disclose Protected Health Information

Name _____
Date of Birth _____

I hereby authorize Willow Creek Counseling Center to release the following protected health information:

[ ] Verbal report by phone or in person including information collected during treatment
[ ] Complete written medical record
[ ] Therapist's personal psychotherapy notes excluded
[ ] Letter summarizing treatment, including dates, diagnosis, assessment results, prognoses, progress, recommendations, observations, evaluations, or other information collected during treatment.
[ ] Intake Form
[ ] Progress Notes
[ ] Master Treatment Plan
[ ] Information about how the patient's condition affects ability to work and daily living tasks
[ ] Billing records
[ ] Psychological Evaluation
[ ] Other (specify any limitations)

Dates of Care : [ ] Entire course of treatment [ ] Limited to these dates: _____

Disclose to this person or organization:

Purposes for Disclosure: _____

Enter a date or event upon which this authorization expires: _____

I understand there are statutes and regulations protecting the confidentiality of information in medical records and that the above information is only released with my understanding and permission. I understand that I can revoke this authorization at any time by sending a written request. I also understand I have the right to inspect and have a copy of the health information described in this authorization. I understand that the person or organization to whom I am releasing this information may not be covered by federal privacy regulations, so the information might not be protected by the entity I have authorized to receive it. I have had the opportunity to have my questions answered about this authorization. I understand my refusal to sign will not affect my abilities to obtain treatment here. I hereby acknowledge this consent is truly voluntary.

I acknowledge that I received a copy of this completed form.

[ ] I do not want a copy of this authorization, but I want the original kept in my medical record.

Relationship to client _____

Date _____

Signature of client or his/her personal representative

_____