RINER COUNSELING, LLC

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Release of Information Authorization Form

This form, when completed and signed by you, authorizes the release of protected information from your clinical record to the person you designate. This often helps in consulting with medical providers/other significant informants who may be assisting in treatment. Please fill in the information below as you believe will be helpful for you and your overall treatment.

I, ____________________________________ (_______________________), authorize and request
(Patient's printed name) (Patient's date of birth)

Dr, Mary-Catherine McClain Riner at Riner Counseling and/or her administrative clinical staff

To ***disclose*** protected health information to the individual named below ❑
To ***obtain*** protected health information from the individual named below ❑
To ***exchange*** protected health information with the individual named below ❑

Name of Individual____ Phone: ___________________

Address____Fax: _____________________

City, State, Ziip____

Type of Information to be Disclosed/Obtained/Exchanged:

Treatment Summary	❑	Medication(s)	❑
Diagnosis	❑	Alcohol/Substance Use	❑
Psychological Testing Results	❑	School/Education Records	❑
Hospital Records	❑	Appointments Kept	❑

(Provide a description of the information to be disclosed. The description should be specific and detailed.)

Purpose of Release: Coordination of Treatment ❑
Other (please specify): *___________________________

Release Format(s)
- ❑ Verbal Communication
- ❑ Written
- ❑ Electronic Media (Fax) for urgent needs only

Expiration Date: _____________________ or until (event) _______________________________
90 Days (date)

I have the right to revoke this authorization in writing at any time by sending such written notification to the office address. I have the right to copy and to inspect the information disclosed and have the right to receive the practitioner's Notice of Privacy Information Form. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and may no longer be protected by the HIPAA Privacy Rule.

I have read and understand the above information and give my authorization voluntarily.

Patient Signature _______________________________ Date ____________________
Parent/ Guardian Signature ______________________________ Date ____________________

Revised 10-4-17