Ince Counseling

PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This authorization is for the use or disclosure of health information pertaining to:

Patient's Name: _____
Last First M.I.

Address: _____
City State Zip-code

DOB: _____ Phone Number: _____

I hereby authorize Ince Counseling & Consulting LLC., 1717 Rhode Island Ave NW, Suite 620, Washington DC 20036, to:

□ Communicate with □ Release Treatment Summary to □ Release Clinical Record to

_____
Name of Person or Organization Receiving Information

_____
Mailing Address City State

_____
Zip Code Phone Number Fax Number

_____ Academic testing results
_____ Intelligence testing results
_____ Personality profiles
_____ Psychological testing results
_____ Summary reports
_____ Vocational testing results
_____ Entire record, except progress notes

_____ Behavior programs
_____ Medical reports
_____ Psychological reports
_____ Service plans
_____ Psychotherapy notes
_____ Progress reports
_____ Others, specify

Purpose: The specified recipient may use the health information authorized on this form solely for the following purpose(s):

_____

_____

_____

Expiration: This authorization becomes effective immediately and shall expire on:

_____
Date

My Rights:

- The person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct may use this medical information for that purpose. The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me, or unless the use or disclosure is specifically permitted by law.

- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

- I have a right to receive a copy of this authorization.

_____

Printed Name of Patient or Personal Representative and his/her relationship to patient

_____

Signature of Patient **Date**