Kopp's Counseling

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Kopp's Counseling and Consulting Services, Inc. to release ( ) all of my mental health information, including assessment, treatment content and dates, summative report, etc., or; ( ) only part of my records from Kopp's Counseling and Consulting Services, Inc. to:

(If only part, indicate by checking one or more of the boxes below, and provide a brief description.)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies only to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ Other: _____

I understand:

- That signing this authorization also allows both entities to share this information for provision of services.
- I have the right to inspect and copy the information to be disclosed.
- I have the right to revoke this consent at any time.
- Revoking this consent shall have no effect on prior disclosures made before withdrawal of consent.
- The information obtained as a result of this release may not be re-disclosed unless I specifically consent to it.
- This authorization shall be considered invalid after twelve (12) months, except for drug and alcohol abuse records authorization which is for two (2) months from the date of signing.

Patient Signature: _____ Date Signed: _____

Witness Signature: _____ Date Signed: _____

THIS AUTHORIZATION IS VALID FOR ONE (1) YEAR FROM THE DATE OF SIGNATURE.