

4886 U.S. Hwy 61, Suite L3, White Bear Lake, MN 55110

Phone: (651) 261-6330 / Fax: (612) 440-2209

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient’s name: |  |  | Address: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Phone: |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DOB: |  |  |  |  |

I authorize Jina Wilson MS, LMFT, RPT of Inner Balance Counseling LLC to use, disclose, receive, and/or exchange protected health information, subject to the specifications below:

(1) The protected health information to be used or disclosd is limited to the follwing information:

|  |  |
| --- | --- |
|  | Diagnosis |
|  | Diagnostic Assessment |
|  | Treatment Plan or Summary |
|  | Case notes/Reports |
|  | Psychiatric Evaluation |
|  | Psychological Evaluation |
|  | Educational information |
|  | Medical Information |
|  | Verbal Communication regarding services and treatment information |
|  | Other: |

(2) Give permission to Inner Balance Counseling LLC to do the following with my information:



|  |  |
| --- | --- |
|  | Disclose information |
|  | Receive Information |
|  | Exchange Information (disclose and receive) |

|  |  |
| --- | --- |
| With the following Individual/Clinic/School: |  |

(3) The reason for the requested use or disclosure is (ie: treatment,billing,discharge planning, etc..):

|  |
| --- |
|  |

(4) This authorization will expire automatically one year from the date signed by Recipient or Legal Representative, or on

|  |
| --- |
|  |

the following date:

**Federal law requires Inner Balance Counseling LLC to tell you that:**

(a) you may revoke this permission at any time by delivering a written notice of revocation to Inner Balance Counseling LLC (b) for disclosures other than for treatment, payment and health care operations purposes, treatment may not be conditioned on my agreement to sign an authorization and (c) HIPAA regulations (42 CFR Part 2) requires Inner Balance Counseling LLC to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by the HIPAA rules.

**I acknowledge and agree to the permission for release/disclose/use of my protected health information:**

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_