



AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize Desert Streams PC, DBA Desert Streams Christian Counseling, to release or obtain my protected health information as specified below.

Information to be released (check all that apply):

- | | |
|---|--|
| ☐ Entire clinical chart (excluding psychotherapy notes unless separately authorized) | ☐ Treatment summary |
| ☐ Psychotherapy Notes | ☐ Labs |
| ☐ Initial clinical assessment / diagnostic impressions | ☐ Medication List |
| ☐ Psychological or Neuropsychological test results | ☐ Closing/discharge summary |
| ☐ Other (specify): _____ | ☐ Billing/insurance information |

Information released to/from:

Name/Agency _____

Address _____

Email / Phone / Fax _____

Purpose of disclosure:

- ☐ At the request of the individual
- ☐ To facilitate treatment/coordinate care
- ☐ Legal or administrative request
- ☐ Other (specify): _____

Duration of authorization:

This authorization will expire in on year OR upon:

- ☐ Case closure
- ☐ One-time authorization
- ☐ Other: _____

Important Notices

- You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that Desert Streams P.C. has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that Desert Streams P.C. generally may not condition psychological or psychiatric services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.
- I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Acknowledgment & Consent

I have read and fully understand the above. I authorize this release as indicated.

Client Name (print) _____ DOB _____

Guardian Name (print), Attach Proof of Authority, if applicable _____ Relationship _____

Client or Guardian Signature _____ Date _____

Witness Signature _____ Date _____