SEASONS
COUNSELING SERVICES

Brooke Kuntz, LISW | 3600 Olentangy River Rd Building D Ste. 104 Columbus OH 43214
(614) 706-2228 Ext. 721

STANDARD AUTHORIZATION FORM

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/ or drug/alcohol treatment, and/or sexual assault.*

AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

Section I

First Name *	**M.I.**	**Last Name***	**Date of Birth ***	**Social Security Number**

Address	**City**	**State**	**Zip Code**

I hereby authorize the disclosure □ or exchange □ of health information about the above individual as follows (check one)

Section II

Disclosing Entity* *(Covered Entity such as a health plan/insurer or provider)*

Address	**Telephone Number**

City	**State**	**Zip Code**

Recipient (Person or Entity) *

Contact Information *(e.g. telephone number, email address, fax number, street address, etc.)*

Section III

Reason for Disclosure*

Health information to be disclosed*

Specify time period, ifdesired:
Release only information from the period_____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will

Expiration Date or Event

- I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.
- I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and

Signature of Individual *	**Date *** *(mm/dd/vwv)*
Signature of Personal Representative (if applicable)* *(identify relationship to individual below)*	**Date*** *(mm/dd/yyyy)*

Relationship of Personal Representative to Individual *(Personal representative shall submit proof of authority to the disclosing entity)*

□ Parent □ Legal Guardian □ Healthcare Power of Attorney □ Executor /Administrator □ 0ther □ N/A

For administrative use only:

Method of Delivery (e.g. paper, fax, electronic,) Date Released ____