AUTHORIZATION TO RELEASE INFORMATION
Patient Authorization for Use and Disclosure of Protected Health Information

By signing this document, I authorize **ANNABEL AGEE, PhD, LPC/MHSP, NCC** to use and/or disclose certain protected health information (PHI)* about me to the following person/s:

Name of person/s: _______________________________ Relationship______________

Address:____

Phone/s:____

Email:____

*Protected Health Information authorized to be released to the above-named person/s by my mental health services provider Annabel Agee, PhD, LPC/MHSP, NCC:

Presence in treatment** **CHECK & INITIAL IF "YES"**	Treatment plan** **CHECK & INITIAL IF "YES"**	Assessment results** **CHECK & INITIAL IF "YES"**
Dates of service** **CHECK & INITIAL IF "YES"**	Session notes** **CHECK & INITIAL IF "YES"**	Other information as specified below** **CHECK & INITIAL IF "YES"**

**Protected Health Information authorized to be released for the purpose of:

Coordination of care **CHECK & INITIAL IF "YES"**	Family communication **CHECK & INITIAL IF "YES"**	Other purpose as specified below: **CHECK & INITIAL IF "YES"**

This authorization to release PHI to the above-named person/s will expire automatically

ONE YEAR from the date signed: AUTOMATIC EXPIRATION DATE:___________
OR AS OTHERWISE SPECIFIED OR AT ANYTIME RESCINDED BY PATIENT as described and dated below when applicable:

I understand that I am not required to sign this authorization in order to receive treatment. I also understand that my provider will honor my right to confidentiality of my protected health information unless I have authorized the release of such information to the person/s named in this document. However, eminent danger to self or others is an exception that overrides confidentiality and consent to release.

My signature below represents that I have had opportunity to ask questions regarding confidentiality and consent and that I have been offered a copy of this signed document.

Signature of patient:_____________________________ Date signed:________________

Witnessed by: Annabel Agee, PhD, LPC/NHSP, NCC____________________________