CALLAHAN COUNSELING SERVICES
Peter J. Callahan, PLLC

Authorization for Release and/or Exchange of Protected Health Information

I, _____ hereby authorize _____.
Print Client Name Callahan Counseling Services

To:

___ Exchange information on an ongoing basis with:

_____
Name of individual, hospital, or agency (Relationship to Client)

_____
Contact information for individual, hospital, or agency

for the purposes of treatment, payment, administrative services.

The specific records/reports to be disclosed shall include: (**Client Must Initial**)

_____ Progress Notes	_____ Social Work Assessments	_____ Diagnostics
_____ Consultations	_____ Treatment/Aftercare Plans	_____ Finances
_____ History & Physical	_____ Social/Family Histories	_____ Academic/Educational Records
_____ Lab	_____ Admission/Discharge Summaries	_____ Legal Records

From the date of the Initial Intake: _____Until the end of treatment _____

This authorization shall remain in force until _____ (up to one year).
Date

NOTE: Callahan Counseling Services, as a health care provider, is forbidden by federal law to re-disclose any information received based on this authorization. However, Callahan Counseling Services cannot protect any information that it has disclosed based on this authorization from re-disclosure by the recipient.

I understand that this Authorization is revocable at any time by signing and dating the designated area at the bottom of this page, except to the extent that action has already been taken on it.

_____ _____ _____
Signature of Client or Representative of Client Printed Name Date

_____ _____ _____
Staff Signature Printed Name Date

I revoke/rescind this Authorization effective on this date _____

_____ _____
Signature of Client Staff Signature

(01/13/12)