Release of Information Consent

Name: ____ DOB: _____________________________

Address: ____ Phone: _____________________________

I authorize: Lucyna M Sonek, MPsych, MA, LPC, LCAS
Counseling & Psychotherapy
240 Hwy 105 Ext, Suite 201 A, Boone NC 28607
828/773-7844 (fax) 828/265-2999

to release clinical information such as diagnoses, treatment recommendations, or other records relevant to benefit determination and for claims administration and payment to:

Insurance: ____

I understand that all information received will be treated as protected health information and kept confidential unless I authorize disclosure or when disclosure is otherwise allowed by state or federal law. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.
I understand that federal law includes the protection of substance abuse information (42 CFR Part 2) as well as of HIV/AIDS information (G.S. 130A-143).

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and that after ***1 year*** *this consent automatically expires.*

I have been informed what information will be given, its purpose, and who will receive the information.

I understand that I have a right to receive a copy of this authorization.

I understand that I have a right to refuse to sign this authorization.

____ ___________________________________

Signature: □ Self □ Legal Guardian Date

____ ___________________________________

Witness Date