Brightside Counseling Services, LLC

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Authorization for use or disclosure of protected health information

I, _____ hereby authorize the administrative or clinical staff of Brightside Counseling Services, LLC to use or disclose the protected health information (PHI) described below to the person and for the purpose set forth below.

1. The person(s) or entity to receive the PHI:

Name: _____
Address: _____
_____
Phone: _____

2. The type of information (PHI) which I authorize to be used or disclosed is (include dates or range if applicable):
_____
_____

3. This PHI may be used or disclosed for the purpose of:
_____
_____

4. Exceptions: _____

This authorization is in effect until either the following date or event: _____, at which time this authorization will expire. I understand that I may revoke the authorization, in writing, at any time, by notifying the releasing organization, but my revocation will not affect any releases made or other actions taken before the date of my revocation.
I understand that the designated information about me may be sent by mail or delivery service, transmitted by fax, electronic mail or electronic file transfer mechanism, or exchanged verbally unless otherwise restricted by me. I agree that a photocopy or fax of this authorization shall be as valid as the original.
I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal law.
I understand that I am not required to sign this authorization form and that my treatment will not be conditioned on whether I authorize the requested use or disclosure of PHI, except, (1) if my treatment is related to research and the use or disclosure is for such research, or (2) my treatment is being provided to me solely for the purpose of creating information for disclosure to a third party, and the use or disclosure is for that third party.
I understand that I may see and copy the PHI to be released pursuant to this form if I so request, and that I will receive a copy of this form after I sign it.

_____
Signature of Client (ages 15 and older) Date Parent/Guardian or Personal Representative Date

_____
Therapist or Witness Signature Relationship/ Authority of Personal Representative Date

This authorization has been revoked by the client (letter in file) effective _____

Recorded by: _____