



**Crosswinds Counseling
Amy Hertle MSW LICSW**

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This form when completed and signed by you, authorized Amy Hertle MSW LICSW to release protected health information from your clinical record to the person you designate.

I, _____, DOB: ___/___/___ authorize Amy Hertle MSW LICSW and/or her administrative and clinical staff to release/exchange:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Educational Issues | <input checked="" type="checkbox"/> Psychiatric/psychological Evaluation |
| <input checked="" type="checkbox"/> Social History Reports | <input checked="" type="checkbox"/> Medication History |
| <input checked="" type="checkbox"/> Physical Examinations | <input checked="" type="checkbox"/> Discharge Summary |
| <input checked="" type="checkbox"/> Psychological Test Interpretation | <input checked="" type="checkbox"/> Treatment for Drug&/or Alcohol Abuse |
| <input checked="" type="checkbox"/> Treatment Plan(s) | <input checked="" type="checkbox"/> Billing Information |
| <input checked="" type="checkbox"/> Other: _____ | <input checked="" type="checkbox"/> Other: _____ |

This information should only be released/exchanged with: _____

The information is being released for the following reasons "AT THE REQUEST OF THE INDIVIDUAL."

This authorization will remain in effect until ___/___/___.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Amy Hertle MSW LICSW generally may not condition mental health services upon my signing an authorization unless mental health services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by HIPPA Privacy Rule.

_____ / ____ / ____
Patient/personal Representative Signature Relationship to Patient Date

(If authorization is signed by a personal representative of the patient, a descriptor of such representative's authority to act for the client must be provided, e.g., "parent", "guardian", etc.)

Amy Hertle MSW LICSW Date

A COPY OF THIS AUTHORIZATION FORM SHALL BE AS VALID AS THE ORIGINAL