Authorization for Release of Information

By signing this form, confidential health information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. Please refer to the Notice of Health Information Privacy Practices for more detailed information. This form is signed voluntarily and you may make changes to this authorization at any time.

Client Full Name: _____ Date of Birth: _____

Home Address: _____ Phone Number: _____

1. I AUTHORIZE Krysttel Stryczek, M.A., MFT, CLC/Bump and Beyond Family Therapy LLC. to
☐ **RELEASE** ☐ **RECEIVE** information to/from the SECOND PARTY as directed below:

2. SECOND PARTY:

Name of Individual/Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____

3. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

☐ Initial Evaluation
☐ Diagnosis
☐ Treatment Plan
☐ Consultation Reports
☐ Assessment reports
☐ Clinical Progress Notes
☐ Clinical/Discharge Summary
☐ All Records except psychotherapy notes
☐ HIV/AIDS-related information *(initial)* _____
☐ Alcohol/Drug treatment *(initial)* _____
☐ Other *(specify):*

4. PURPOSE OF DISCLOSURE:

☐ Consultation (verbal)
☐ Personal Use
☐ Insurance/Health Benefits
☐ Legal
☐ Evaluation
☐ Coordination of Care
☐ Other *(specify)*

5. Note any exclusions/limitations here:

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT dependent on my signing this Authorization. By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to disclose my records, and that I may revoke this Authorization, except if this Authorization was obtained as a condition of obtaining insurance coverage, at any time by providing a written notice to Krysttel Stryczek, M.A., MFT, CLC. The revocation shall be effective except to the extent that Krysttel Stryczek, M.A., MFT, CLC has already used or disclosed information in reliance on the Authorization. I understand that my information may be disclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. I release all parties stated here from any liability resulting from the release of this information. I am giving my consent freely and voluntarily, and the benefits and disadvantages or releasing the information, if known, have been explained to me.

This consent form will expire when treatment is terminated or upon the following event: _____, whichever comes first, unless earlier revoked by you in writing.

Client Signature: _____ Date: _____