# Four Points Counseling Center

## Authorization to Exchange Protected Health Information

I authorize Four Points Counseling Center (FPCC) to disclose my health information to the following entity or individual as well as receive health information from said entity or individual.

**Entity/Individual:** _____ **Phone number:** _____

**Relationship to Client:** _____

I understand that disclosure may occur orally, in writing or via electronic transmission. This authorization permits Four Points Counseling Center to disclose the following information about me (check all that apply):

_____ Presence in Treatment
_____ Mental Health Record Summary
_____ Treatment Plan/ Plan Summary
_____ HIV/AIDS Diagnosis/Treatment Information
_____ Psychological Test Results
_____ Discharge/Transfer Information
_____ Assessment/Evaluation
_____ Treatment Progress
_____ Progress Notes
_____ Diagnosis

_____ Other (please state below):

**Revocation**
I understand that I have the right to revoke this authorization at any time. I understand that revocation or modification of this authorization must be provided in writing to FPCC staff to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

This authorization will expire six months after termination of treatment with FPCC. If an alternative expiration is desired, please indicate so here:

**Redisclosure**
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a state law applies that is more strict than HIPAA and provides additional privacy protections.

**Authorization**
I understand that only the individual who has consented for care, including a minor as required or permitted by state law, can authorize the release of protected health information (PHI). I understand that I have the right to withhold my consent and refuse the signing of this authorization. My provider shall not condition my treatment upon this refusal. I understand that I am voluntarily signing this form to release my health information to the party or parties designated.

Client Name (Printed): _____ Client Date of Birth: _____

Client/Representative Signature: _____ Today's Date: _____

*Representative relationship to client:* _____