Creason Counseling
5511 E. 82nd Street, Suite K
Indianapolis, IN 46250
317-721-9585

AUTHORIZATION FOR RELEASE OF CLIENT HEALTH INFORMATION

Client's full name: _____ Date of Birth: _____

I hereby authorize: **KATE CREASON, MSW, LCSW____**
SHANNON BRANIC, MSW, LCSW_____
to receive from or share with organization named below, client's protected health information.

Person/Organization: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Purpose for exchanging the information: __Coordination of Care __Treatment Planning __Other: _____
_____
_____

Exchanges will include the following information:
__Assessment __Treatment Plan __Progress Notes __Clinical Summary
__Diagnosis __Dates of Service __Type of Service __Videotape of session

Re-release of other records from other providers, specify: _____
_____
_____
Records from the period from: _____

This Release will expire on: _____(this release will expire on same day as signed by the Client if no specific date is provided).

I understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to Creason Counseling except to the extent that action has already been taken to release this information. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. If I refuse to release information, it may negatively impact my quality of care in that providers will not be able to coordinate care between each other which may limit my recovery. RE-DISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization and the recipient named above that the health information disclosed under this Authorization may not be re-disclosed by the recipient to others without the written consent of this client. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding diagnosis or treatment for HIV or drug/alcohol abuse.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Legal Guardian/Representative Date

_____ _____
Witness Date

Record of Disclosures of PHI

Date of Release	Information released