Mandy Millsap, LMHC
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Authorization for Use/Disclosure of Protected Health Information Under the Health Insurance Portability and Accountability Act (HIPPA)

Client Name:_____ DOB: _____

I hereby request and authorize Center Peace Counseling to release and obtain any protected Medical, Substance Abuse, and Mental Health Information whether written or verbal of the above-named individual to:

_____

_____

_____

I further authorize the above names people/entitles to release any Medical, Substance Abuse, and Mental Health Information whether written or verbal to Center Peace Counseling.

I understand that my authorization shall remain effective for a minimum period of one year from the date of my signature, except that I may revoke this authorization at any time by making a written request to Center Peace Counseling. I understand that my treatment is not conditional upon the signature on this document. I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders, mental health or drug treatment or use.

_____ _____
Client's Signature Date