Reflections Counseling Services
Michelle Juarez, LPC, CSAC
317 Office Square Lane Suite 202B
Virginia Beach, VA 23462
757-932-0040
michelle@reflectionscounselingvb.com

Authorization for Use or Disclosure of
Protected Health Information

Client Information

Client Last Name:_________________ First Name:_________________MI: _________
DOB:___/___/____
Client Address:____
Client Home Phone: _____________________Cell/Work:____
Phone:____
Client Email Address:____

Recipient Information

I, ____ do hereby authorize
Michelle Juarez LPC, CSAC, NCC of Reflections Counseling Services to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: ____

Phone:____
Address: ____
Date of Authorization: ___/___/______
Authorization to expire on ___/___/______ or upon the happening of the following____

Information to be Released:

Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)
☐Treatment Progress
☐Treatment Plan
☐Discharge Summary
☐Psychological Evaluation and Assessment
☐My entire mental health record
☐Only those portions pertaining to:
☐Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for ☐Psychotherapy (Notes, you must not use it as an authorization for any other type of protected health information.)
☐Other:____

Purpose of Information Release:

☐Further mental health care ☐Payment of insurance claim
☐Legal investigation ☐Applying for insurance
☐Vocational rehab, evaluation ☐Disability determination
☐At the request of the individual
☐Other (specify): ____

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Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

____

Signature   Date

If signed by a personal representative:

(a)Print your name:____

(b)Indicate your relationship to the client and/or reason and legal authority for signing:

Client is a: ☐minor ☐incompetent ☐disabled deceased

Legal authority ☐parent ☐legal guardian ☐representative of deceased