Resilient Counseling, PLLC
515 Keisler Drive, Suite 101
Cary, NC 27518
Office: 919.868-6242; Fax: 919.510.6262

Consent to Disclose Protected Health Information (PHI)

CLIENT NAME:_____ DOB:_____

I authorize and request Angela S. McLean, LMFT of Resilient Counseling, PLLC to release information and/or exchange information from the medical records of the client listed above to and from:

_____
_____
_____

for the purpose of assessment, collaboration, sharing with other healthcare providers as needed, consultation, treatment planning, referral, insurance processing and/or any coordination of mental health services.

Please indicate which documentation regarding your treatment may be released and/or exchanged. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.

☐ Information contained in the client's medical record related to psychotherapy, diagnosis, status, symptoms, progress, prognosis, treatment, and discharge.
☐ Information contained in the Patient's medical record related to treatment for alcohol and/or drug abuse/use.

☐ Information contained in the client's medical record related to treatment for HIV/AIDS

This Authorization shall cover actions by and for Resilient Counseling, PLLC and all of their respective employees, workforce, and business associates. This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to Resilient Counseling, PLLC (see address above). Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation. I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal and/or state privacy laws may not protect the re-disclosure. I understand authorizing the disclosure of information identified above is voluntary and this Authorization is not intended to alter the client's ability to receive medical care from any health care provider.

This authorization will expire on the following date or event: _____
If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

I understand that I may refuse to sign this authorization form and understand that Resilient Counseling, PLLC will not alter my treatment or any payment if I refuse to sign.

_____ _____ _____
Date ***Signature of Client/Parent/Legal Representative Signature of Witness

**If the client is under 18 years of age, unless the Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the minor-client's behalf. By signing this form for someone else, you as the parent, guardian, a party acting in loco parentis, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.