CLIMB
Counseling LLC

Authorization to Disclose Protected Health Information

Client Information	Please print clearly.	Name: _____ Date of Birth:_____ Other names used: _____ Phone: _____ Parent/legal Guardian: _____
Health Care Provider, Person, Agency, Emergency Contact	With WHOM may CLIMB CLINIC share/receive info?	Clinic/Physician/Provider/Person: _____ Relationship to Client: _____ Phone: _____ Fax: _____ Address: _____
Communication	HOW will Climb Clinic share/receive information?	___ Exchange the information indicated below (verbal communication, sending/requesting paper copies of records via mail/fax). ___ ONLY verbally communicating the information as needed for purposes identified below.
Information to be Released	Please check all that apply.	___ All records ___ Intake Evaluation/Diagnostic Assessment ___ Therapy documentation ___ Treatment plans ___ Discharge summaries ___ Administrative records (appt listings/billing)
Purpose		___ Coordination of care ___Discharge & Continuation of care ___ Client request ___ Insurance ___ Legal purposes ___ Other: _____

Statement of Authorization

I understand the following:

- I may revoke this consent at any time, except to the extent that Climb Counseling has already acted in reliance on it, by providing oral or written notice.
- I have been informed what information will be released, its purpose and who will receive the information. I may inspect or copy the protected health information to be used or disclosed under this authorization where applicable state and federal laws apply.
- I understand that I may refuse to sign this authorization. Climb Counseling will not condition treatment, payment, enrollment or eligibility for services based on signature.

Client Signature: _____ Date: _____

_____ Date: _____

Legal representative (where applicable): I am legally authorized to represent the client listed above and I understand that I may be asked to provide documentation to demonstrate this legal authority.