Authorization for Release of Health Information

Client Name _____ **Date of Birth** _____

This authorization will expire:

___ When Information is received
___ In six Months
___ On date _____
___ In one year
___ In Three Years

The person named above is or has been a client of:

Reach Counseling, LLC
873 Baxter Dr.
South Jordan, Ut. 84095

The client named above hereby authorizes Reach Counseling to have a two-way communication with:

Individual/organization Address and/or phone number
Primary Care Physician Name:_____ Phone: _____
Others_____
_____
_____
_____

Emergency Contact:_____ Phone:_____

For the following: (Client initial each selected preference)

___ Request Information
___ Discuss Health Information
___ Billing/Account Information
___ Send Mental Health Information
___ Discuss Mental Health Information
___ Crisis Interventions

Scope:

___ All information regarding assessment, diagnosis, and treatment of patient's condition, or concern.
___ All information regarding care received by patient between dates of _____
Start date

And _____.
Ending date

Authorization (parent/Guardian sign if client is a minor)

Print Name _____ Relationship to client_____

Sign Name _____ Date _____

___I do not want to authorize Reach Counseling, LLC any contact with individuals/organizations/support at this time.
(Signature):_____Date:_____