Cary Scott Counseling
A NEW DAY, A NEW EXPERIENCE, A NEW BEGINNING

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AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION*

PATIENT'S NAME: _____ BIRTH DATE:_____

I, _____, residing at _____, hereby give my consent to Cary Scott, to release and receive personal health information contained in my clinical records regarding:

Mental health: _____ other: _____
Medical history: _____ _____
Family history: _____

To/From:

Recipient/Provider of Confidential Info: _____

Relationship to Patient: _____

Phone Number(s): _____ Fax: _____

Address: _____

For the purpose of ("continuity of care" if left blank):

_____ .

I understand that this is valid until (indefinite if left blank) _____, that I may withdraw my consent at any time, and that I have a right to receive a copy of this authorization form. I also understand that the information being disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by this privacy rule.

_____ _____

Patient Signature Date

* Compliant with the *Health Insurance Portability and Accountability Act* (HIPAA).