Nancy De Haas, LPC-S
Valley Christian Counseling
5151 Research Drive NW
Huntsville, AL 35805
Phone: (256) 722-8091 Fax: (256) 722-1366

REQUEST/AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby consent to, direct and authorize Nancy De Haas, LPC-S to ( ) provide, ( ) obtain, or ( ) exchange information concerning my psychological or medical history/treatment. Authorization and disclosure of protected health information is thus granted to Nancy De Haas LPC-S and/or to the following person or agency:

____ ____
Name Facility/Center/Organization and Phone or Fax Number

____
Address City State Zip

Authorized information pertaining to____Date of Birth__________________________

Information to be obtained/released/exchanged:

___Presence in program
___Initial Evaluation/History
___Description of progress and prognosis
___Results of observations and assessments
___Educational records including achievements, assessments and attendance
___Psychiatric/Psychological Reports
___Any and all records/information
___Other (Specify)____
___Therapy Notes
___Billing Records
___Transfer/Termination Summary
___Medical Information
___Intervention Plan
___Tests taken and test scores
___Consultations

Purpose of this Authorization

___Facilitate evaluation and ongoing treatment/continuity of care
___Provide educational services/school placement or assessment/coordination of services
___Coordinate intervention efforts with family/concerned person
___Provide information for insurance purposes
___Other

Read Carefully: I acknowledge and understand that my medical/behavioral health records are confidential. I further acknowledge and understand that I am waiving my right to confidentiality with respect to the records from any person and all liability arising from release and disclosure of the information and records to the above named person. Drug and/or alcohol abuse information records are specifically protected by federal regulations (42CFR Part 2). By signing this authorization, I am allowing the release of all records indicated above from the agency or person specified to the person above. Federal regulations prohibit the recipient of the information from making further disclosure without the specific, written consent of the responsible person, or as otherwise permitted by law or regulation. This consent may be revoked at any time except to the extent that action has already been taken. This authorization will expire on _____________________. (If left blank, this authorization will automatically expire 90 days after case closure).

____ ______________________________________ _________________
Printed Client Name Signature of Client Date

____ ______________________________________ _________________
Signature of Parent/Legal Guardian or Legal Representative Relationship to Client Date

____ _________________________ _________________
Client Address Client Telephone Number Client Date of Birth

Witnessed by:

____ ______________________________ ____________________________
Nancy De Haas, LPC-S Or Printed Name of Witness Signature of Witness