



ALIGNED
COUNSELING

Authorization for Reciprocal Release of Protected Health Information

Legal name:

I, _____, hereby authorize Aligned Counseling, PLLC to
release information to/from:

Agency/Facility/Person:

Email address:

Telephone number:

This authorization permits the exchange of the following information:

Medical history and evaluations Mental health evaluations Discharge summary
 Developmental and/or social history Educational records Progress notes
 Treatment plans Record Abstract (All of the above options) Other (please
specify):

This abstract will include sensitive information such as substance abuse and HIV/AIDS unless
checked below. Only check if you **do not** want this information shared:

Substance Abuse HIV/AIDS Other: _____

These records are released for the purpose of (check all that apply):

Continuity of Care Attorney/Client Relationship

Determining eligibility for benefits or program At the request of the client

This authorization shall be in force and effective until the following event and/or date:

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following:

Molly McLeese, Owner of Aligned Counseling PLLC
molly@alignedcounselingchicago.com

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature of Client or Legally Authorized Representative Date _____

Relationship to Client

Signature of Witness Date _____