KIM SMALL, LPC

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AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient Name: ____ Date of Birth: ___________________________

I, the undersigned, do hereby authorize you to:

( ) Furnish records TO Kim Small, LPC from: ____

( ) Furnish records FROM Kim Small, LPC to: ____

Please initial to Specifically Authorize the use and/or Disclosure of (initial each requested item):

( )	Emergency Room/Urgent Care Records	( )	Admission Notes
( )	Hospital Records (Nursing & Progress Notes	( )	Discharge Summary
( )	Initial Psychiatric Evaluation	( )	Clinical Summary
( )	Medication History	( )	Psychological Test Reports
( )	Outpatient Progress Notes	( )	Verbal Discussion of Care
( )	Consultation Reports	( )	Written Reports to Coordinate Care
( )	Laboratory Results	( )	Billing Statements
( )	Other (specify)		

The requested records or information is about health care provided during the following approximate time frame: _______________________ to _______________________

The purpose of this disclosure is (Please check): ( ) Coordination of Care ( ) Transfer Care

( ) Other (specify): ____

The authorization expires on: ( )___________________ ( ) A year from this date.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations. The use of disclosure requested under this authorization will result in direct or indirect remuneration to Kim Small, LPC.

I understand that I can revoke this authorization at any time in writing to Kim Small, LPC.

I understand that Kim Small, LPC cannot condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless treatment is related to research and the purpose of this authorization is to engage to protected health information described abuse to be used for such research.

I have received a copy of this authorization: ______ Yes ______ No

Patient Signature: ____ Date: ______________________________

Relationship/authority (if signed by authorized representative): ____

Witness Signature: ____ Date: ______________________________