LOIS THOMSON BOWERSOCK & *associates, llc*

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CONSENT FORM

Authorization Consent for the Use and Disclosure of Protected Health Information

Notice to Recipients of Information:

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Par2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Person, agency or entity to whom information is to be released:

Name

Street Address **Apt. #**

City **State** **Zip**

Phone **Fax** **Email**

This document authorizes Lois Thomson-Bowersock & Associates, LLC to disclose information concerning:

Name(s)

Street Address **Apt. #**

City **State** **Zip**

Email **Date of birth**

I, the undersigned, hereby consent to, direct and authorize Lois Thomson-Bowersock & Associates, LLC to release or disclose confidential records or protected healthcare information pertaining to my treatment and counseling process with

the above stated person, agency or entity.

The records or protected health information to be released and disclosed should include:

- [ ] Initial Assessment/History
- [ ] Treatment Plan
- [ ] Progress Notes
- [ ] Billing Records
- [ ] Transfer/Termination Summary
- [ ] Tests Taken and Testing Scores
- [ ] Any and all records and/or protected health information

Other (specify)

The purpose of this disclosure is to:

- [ ] Facilitate treatment
- [ ] Comply with legal requirements
- [ ] Facilitate financial considerations for third-party payors

Other (specify)

I acknowledge that I have the right to revoke this authorization in writing at any time to the extent that Lois Thomson-Bowersock & Associates, LLC has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected heath information could possibly still be compelled by Court Order under state law as indicated in the copy of the Privacy Notice of Lois Thomson-Bowersock & Associates, LLC that I have received and reviewed.

I acknowledge that I have been advised by Lois-Thomson-Bowersock & Associates, LLC of the potential of the redisclosure of my protected health information by the authorized recipients and that it will no longer be protected by the Federal Privacy Rule. I acknowledge and understand I am waiving my right to confidentiality with respect to the records and protected health information released pursuant to this consent.

I further acknowledge that the treatment provided to me by Lois Thomson-Bowersock & Associates, LLC was not conditional on my signing this authorization.

This consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon. This consent, unless sooner revoked, is valid until:

Day **Month** **Year**

(Condition date or event upon which consent will expires without express revocation).

Name

Street Address **Apt. #**

City **State** **Zip**

Phone **Fax** **Email**

Date of birth

I acknowledge that I have received a copy of this signed authorization from Lois Thomson-Bowersock & Associates, LLC

Client signature **Date:**