

Snapdragon Counseling
Authorization to Release/Exchange PHI

I, _____, authorize the release of the Protected Health Information (PHI) below from Snapdragon Counseling to share the information listed below to the following individual/organization:

Individual name:

Organization name (if applicable):

Phone number:

Email:

Address (if applicable):

I give Snapdragon Counseling permission to disclose (choose one):

- ☐ My full treatment record disclosure including demographics, diagnoses, treatment plans, progress notes, and billing information
- ☐ My full treatment record excluding specific categories:
 - ☐ Diagnoses
 - ☐ Information pertaining to alcohol/drug use or treatment
 - ☐ Progress notes
 - ☐ Billing information
 - ☐ Other:

Reason(s) for disclosure:

- ☐ Coordination of care
- ☐ Legal/financial purposes
- ☐ Personal/at my request

This authorization to share information shall be valid until (choose one):

- ☐ 2 years from today's date
- ☐ The following date:
- ☐ Indefinitely or until I revoke it

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by completing the bottom section of this form.

I understand that in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data. I understand signing/submitting this authorization (or the cancellation of this authorization) will not affect my eligibility for treatment or services with Snapdragon Counseling.

Signature:

Printed name:

Date:

Revocation of Authorization to Release/Exchange PHI

I, _____, hereby revoke authorization for Snapdragon Counseling to share my Protected Health Information (PHI) with any outside parties (except those covered by HIPAA or required by law).

Reason for revocation:

Signature:

Printed name:

Date: