Cathy Lebeaux, MA, MS, LPC, BC-DMT

Psychotherapy & Expressive Arts Center, LLC, 222 Coleman Blvd, Mt. Pleasant, SC 29464

HIPPA Authorization Release Form

Client Name:_____ DOB:_____

Release to:_____

Address, phone number, fax, &/or email: _____

My signature on this ROI indicates my permission to release information by the above method

Authorization:

I request and authorize Cathy Lebeaux, MA, MS, LPC, BC-DMT, to release the following information specified below to the organization, individual, or agency named above. I understand that the information released may include my entire mental health record including, medical records, prescription history, medications prescribed as well as any other protected health information about me. This may include diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes unless explicitly requested below.

Information Requested:

Unless otherwise specified, the information released verbally and/or in written form, may include (1) copies of complete chart including any records from other healthcare providers contained in the chart; (2) copies of outpatient, inpatient, and ER admissions; (3) other requested and permitted information. Unless specified or restricted below the information request will cover the entire client record. **Any requests to limit or release additional information must be listed below.**

_____ My initials indicate I **WOULD** like my psychotherapy notes included.

_____ My initials indicate I would **NOT** like my psychotherapy notes included (default if no choice)

Purpose of Disclosure:

My signature of the next page acknowledges that any previous agreements I have made to restrict my protected health information do not apply to this authorization and I instruct Cathy Lebeaux to release my entire mental health record without restriction, unless otherwise limited above. This information

maybe used to obtain the necessary information, written and/or verbal, to manage my medical care, assist in my future treatment planning and living arrangements, and/or investigate or defend against any claim made by or on my behalf.

Revocation Rights:

I understand that I have the right to revoke this authorization in writing at any time, by providing written notification to Cathy Lebeaux. I understand this revocation becomes effective upon receipt by Cathy Lebeaux, and that such revocation is not effective to the extent that any of my providers have already relied on this authorization to disclose information about me. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be disclosed by Cathy Lebeaux except as authorized by me or as required by law. I understand that the recipient of this release may further disclose this protected information without my consent. This authorization maybe used multiple times until it expires. A PHI log will be kept of each disclosure and the client will be notified at each use.

I understand that Cathy Lebeaux will not condition therapy on whether I sign this authorization, but that if I refuse to sign or restrict what is released, my care may be compromised. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Client or representative's signature:_____Date:_____

Printed name of client's representative_____

Relationship to client:_____

This authorization will expire at the end of therapy or on the following date:_____