Blue Mountain Center for Integrative Health
1064 Meadowview Drive, Suite #5, Boone, NC 28607
Phone: 828-265-1455
Fax: 828-265-1535

CONSENT FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations.

Client Name: ____
(First) (Middle/Maiden) (Last)
Social Security #: ________________________________ Date of Birth: _____________________

The following individual/organization at Blue Mountain Center for Integrative Health (address and phone numbers above) indicated below is authorized to exchange health information:

____ Susan E. (Suzi) Woodard, LPC ____ ______________________________
____ Thomas A. Woodard, LPC, LCAS ____ ______________________________

This health information may be exchanged with the following individual or organization:

Name: ____ Telephone: ________________
Agency/Organization: ________________________________ FAX: ____________________
Address: ____

I understand that the information in my medical record may include information relating to diagnosis or treatment of drug or alcohol abuse/addiction, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted infections, AIDS, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), and/or human immunodeficiency virus (HIV).

Purpose of Disclosure:

____ Coordination of treatment services
____ Referral for additional services
____ Diagnostic assessment information
____ Transfer records from prior treatment
____ Other: ______________________________

I understand that I have the right to revoke this authorization at any time by notifying my therapist in writing or by completing the Revocation portion of this form (below) at that time. I understand that any such revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization.

This authorization will automatically expire in six (6) months unless otherwise specified here:
____

Printed Name: ______________________ Signature: ________________________ Date: ________
(Patient or Authorized Representative)

If Authorized Representative, please indicate relationship to patient:

____ Spouse ____ Parent ____ Other: ________________________________

Please Note: If information relating to the treatment of drug or alcohol abuse is being released, for a patient under age 18, the patient must also sign the authorization.

Signature of Minor: ____

Witnessed by: ______________________ Signature: ________________________ Date: ________
(Print Name)

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REVOCATION of Consent to Release Information

I hereby revoke the use or disclosure of my identifiable health information as described above. I understand that this revocation does not apply to information that has already been released in response to my prior authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Client Name: ______________________ Signature: ________________________ Date: ________