LifeBalance counseling

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Schaumburg, IL 60173

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info@lbcounseling.com

IS132 Summit Ave, Suites 207B, 305A/B
Oakbrook Terrace, IL 60181

509 Old Northwest Hwy, Suite 210F
Barrington, IL 60010

Patient Name:

Date of Birth:

I hereby authorize Life Balance Counseling and its affiliated mental health therapists and health care providers to use or disclose my protected health information (PHI) to _____ for the following

purpose: _____.

I authorize the release of my PHI covering the period of health care (check one):

□ from (date) _____ to (date) _____ OR

□ all past, present and future periods.

I hereby authorize the release of my PHI as follows (check one):

□ my complete health record (including records relating to mental health care and psychotherapy notes, communicable diseases, HIV/AIDS, and treatment of alcohol/drug abuse)

OR

□ my complete health record with the *exception* of the following information: □ mental health records

□ communicable diseases (including HIV/AIDS)

□ alcohol/drug abuse treatment

□ other (please specify): _____

By signing below, I understand that:

My treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I choose to sign this authorization form.

I may revoke this authorization at any time in writing to the Privacy Officer at Life Balance Counseling; however, the revocation will not affect any uses or disclosures that were made prior to Life Balance Counseling receiving the revocation.

The information disclosed pursuant to this authorization form may be subject to re-disclosure by the recipient of the information and thus, will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).

This authorization form is valid from the date it is signed and will expire on (date) _____, unless I revoke this authorization prior to the expiration event.

I have read the above and understand the contents of this authorization form and as such, I authorize the use or disclosure of my PHI.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Personal Representative (if applicable) Relationship to Patient