MAP YOUR CARE:
ILLNESS & GRIEF
COUNSELING, LLC

Bonnie Herrmann, LCSW, ACHP-SW
(720) 414-0320 | bonnie@mapyourcarecounseling.com

RELEASE OF INFORMATION

Client's Name:

Your relationship to client:

_____ Self
_____ Proxy/Surrogate Decision Maker
_____ Legal Guardian/Power of Attorney.
_____ Other: _____

I authorize Map Your Care: Illness & Grief Counseling, LLC to:

_____ send
_____ receive

The following information:

_____ Medical history and evaluation(s)
_____ Mental health evaluations
_____ Developmental and/or social history
_____ Educational records
_____ Progress notes, and treatment or closing summary
_____ Other: _____

To / From: _____

Address: _____
City: _____
Phone: _____
State: _____
Fax: _____
Zip Code: _____

The above information will be used for the following purposes:

_____ Planning appropriate treatment or program
_____ Continuing appropriate treatment or program
_____ Determining eligibility for benefits or program
_____ Case review
_____ Updating files
_____ Other: _____
_____

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I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

_____
Date

_____ _____
Printed Name Signature

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.