Bloom Counseling, LLC

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Huntsville, AL 35801
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Authorization to Release Health Information

I hereby authorize the use and disclosure of any protected health information as set forth below.

I understand that I may revoke this authorization at any time by notifying my provider in writing. In the event of any revocation of this authorization, the revocation will not affect any action taken by the provider in reliance on this authorization.

I understand that the provision of treatment or health care may not be conditioned on my providing this authorization.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the federal privacy regulations.

By signing below, I authorize Louisa N. DiLeone, LPC-S and Bloom Counseling, LLC (and/or administrative staff, if applicable) to exchange (receive and release) confidential information about my health treatment/services (including mental health services) with the persons/agencies listed below:

Insurance company (required if using insurance to pay for services) _____

Primary care provider _____

Specialty provider (e.g., psychiatrist, dietitian, etc.) _____

Specialty provider (e.g., psychiatrist, dietitian, etc.) _____

School / School District _____

Family Member _____

Other _____

Disclosure will be made for the purpose of coordination of care and/or access to insurance benefits.

This authorization will be valid for one (1) year from the date of signature, unless otherwise specified as expressed by the patient, parent, or guardian in writing, prior to that date.

Client's Name *(printed)* _____ Date of Birth _____

Signature _____ Today's Date _____

Relationship to client _____ *(if other than client, e.g., parent, legal guardian)*

Witness _____ Date _____