Timpanogos Counseling

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I hereby authorize that health care information for:

Client Name: _____ Date of Birth: _____

Be mutually exchanged between:

Timpanogos Counseling/Bonnie Hatch		_____
309 N State St		_____
Orem, UT 84057	and	_____
Phone: (801) 885-6762		_____
Fax: (801) 434-8333		_____

For the purpose of:

_____ Diagnosis and treatment _____ Coordination of care

_____Payment of services _____ Psychological evaluation

Timpanogos Counseling

The information requested or authorized for release or exchange is limited to the following:

_____Discussion of treatment

_____Any and all records from _____ to _____

_____Hospitalization records from _____ to _____

_____All relevant clinical information, including diagnosis, course of treatment of _____

_____Summary of treatment for _____

_____Other: _____

I understand:

1. That my records are protected under Federal and State statutes and cannot be disclosed without my written consent unless otherwise provided for in the statutes.
2. That I may revoke this consent, in writing, at any time except to the extent that action has already been taken relative to it.
3. That my specific permission is required to release any health care information regarding testing, diagnosis or treatment for HIV (AIDS virus), communicable/sexually transmitted diseases, psychiatric disorder, mental health, drug or alcohol treatment.
4. That a photocopy of this consent shall have the same effect as the original.

_____ _____

Print Name (Client/Legal Guardian) Date

_____

Signature

_____

Witness