Eleni Economides LMFT
Individual, Marriage and Family Therapy
Couples and Relationship Counseling

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CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

Authorization for Disclosure of Protected Health Information

Client Name:_____ Date of Birth:_____

I authorize Eleni Economides, LMFT to disclose and/or receive the the requested outpatient psychiatric evaluation and/or treatment information, including protected health information, as specified below.

Information may be ❑ released to ❑ received from:

_____ _____
Name of Person/Provider/Organization/Facility or Program Contact Name

_____
Address

_____ _____
Phone Fax

Purpose of this Request:

❑ Healthcare/Treatment Coordination ❑ Personal ❑ Legal
❑ Discharge Planning ❑ Insurance Coverage ❑ Other

Specific Information Authorized (*please select one or more as appropriate)*:

❑Evaluations/Assessments ❑Diagnostic Impression ❑ Progress Notes
❑ Entire copy of the Outpatient Record ❑Discharge Summary ❑ Medical History
❑Progress in treatment ❑Treatment Summary ❑ Treatment Plans
❑Other _____

My authorization will expire:

❑ When the requested information has been sent/received
❑ 90 days from this date ❑ One year from this date ❑ Other _____
❑When I am no longer receiving services from _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Eleni Economides LMFT at the above address. However, my revocation will not be effective to the extent that actions have been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my therapist generally may not condition therapeutic services upon my signing an authorization unless the therapeutic services are provided to me for the purpose of creating health information for a third party.
I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date