life stone
Counseling Centers

Client Authorization for Release of Protected Health Information

Client Name (First / Middle / Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number*: _____ DOB: _____ Phone: _____

* Providing your Social Security Number is voluntary but necessary to accurately identify your medical records.

1. I authorize the following health care provider or facility **TO RECEIVE & DISCLOSE** my patient information:
   Life Stone Counseling Centers, 613 East Fort Union Blvd Ste 104 Midvale, UT 84047, phone: 801-984-1717
2. I authorize the following person or organization **TO RECEIVE & DISCLOSE** my patient information:
   [Court, Judge, Probation/Parole Officer, Attorney, Medical Provider, Therapist, Clergy, Family, Friend, Employer]
   - ☐ Name/Organization/Phone# : _____
   - ☐ Name/Organization/Phone# : _____
   - ☐ Name/Organization/Phone# : _____
   - ☐ Name/Organization/Phone# : _____
   - ☐ Name/Organization/Phone# : _____
3. Please disclose the following information: Assessment, Treatment, Compliance, Completion and Referral.
4. Discloser may occur to: Obtain Information, Provide Updates, Facilitate Court Process, and Provide Referral.
5. I understand that sanctions may be applied if I revoke my consent.
6. If applicable, I understand that based on the information I have designated above, the disclosure Life Stone makes pursuant to this authorization may include information regarding my participation in mental health treatment. I understand that mental health treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164.
7. If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
8. I understand that Life Stone will not condition treatment, payment enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used under this authorization. Fees may apply.
9. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Life Stone/Medical Records, 613 East Fort Union Blvd Ste 104 Midvale, UT 84047. I understand my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires 1 year from the date below.

I have read the above, understand it, and hereby give my consent to the above-mentioned receipt & disclosure.

_____ _____
Signature of Patient Representative* Date

*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian