Redwood Counseling, LLC
325 N 10th Street
Suite 400-341
Lewisburg, PA 17837
Phone: 610-984-5507
Fax: 570-397-9146
Email: wendy@redwoodcounselingllcpa.com
Web: redwoodcounselingllcpa.com

HIPAA Authorization for Release of Protected Health Information (PHI)

1. Patient Information

Patient Name: _____

Date of Birth: _____

Patient Address: _____

Phone Number: _____

2. Information to be Released

- **Specify the type of information to be released:**

  Date(s) of Service / Date Range: _____

  - ☐ All records regarding my mental/behavioral health treatment
  - ☐ Progress notes*
  - ☐ Billing records
  - ☐ Treatment Summary
  - ☐ Discharge Summary
  - ☐ Biopsychosocial Assessment/Intake Form
  - ☐ Medications
  - ☐ Other: _____

  **Progress notes may have practice and legal restrictions. Please contact practice for a more detailed explanation.*

- **The purpose of this use or disclosure:**
  - ☐ Patient request
  - ☐ Insurance
  - ☐ Legal
  - □ Continuity of care
  - □ Other (please specify): _____

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3. Recipient of Information

Name of Recipient/Entity: _____

Address of Recipient: _____

Purpose of Disclosure: _____

4. Authorization

I, _____, hereby authorize Redwood Counseling, LLC to release the above-described Protected Health Information (PHI) to the designated recipient.

5. Expiration Date

This authorization will expire on: _____ (date not to exceed one (1) year).

6. Revocation of Authorization

I understand that I may revoke this authorization in writing at any time. Revocation will not apply to any information already released in reliance on this authorization.

7. Patient Signature and Date:

Patient Signature Date: _____

8. Witness (Practice Owner):

Witness Signature Date: _____