Amy R. Paul LPC PC
Licensed Professional Counselor
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amyrpaul.com

Authorization to Release Confidential Records and Protected Health Information

Client Name: _____ DOB: _____

I hereby authorize: Amy R. Paul LPC PC to use or disclose the following information:

❑ Dates of treatment(s) and treatment summary

❑ Evaluations, reports, assessments, progress notes, treatment plans, summaries or other documents with diagnosis, prognosis, recommendations or testing records and behavioral observations or checklists completed by any staff member or the client or client's parent(s) or legal guardian(s) or similar documents

❑ Educational records, including psycho-educational evaluations, IEPs, reports of teachers' observations and all other school or special education documents

❑ Billing/payment records

❑ Other: _____

To This Person or Organization: _____

Address, Phone Number, Email: _____

The information will be used for the following purposes:

❑ Further mental health evaluation, treatment or care ❑ Treatment planning

❑ Coordination of care ❑ Other: _____

I authorize recipient of information and Amy R. Paul LPC PC to communicate about the reasons for the client's referral, any relevant history or diagnoses and other similar information that can assist with the client receiving treatment, being evaluated or being referred elsewhere.
I understand and agree:

- This authorization will be valid and in effect for one year from the date I have signed the form. After that date, no more of this information can be used or released to the person or organization unless I sign a new authorization.
- I can revoke or cancel this authorization at any time by sending a letter to Amy R. Paul LPC PC. If I do this, it will prevent any releases after the date it is received but can not change the fact that some information may have been sent or shared before that date.
- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Amy R. Paul LPC PC.
- I understand that I may inspect and have a copy of the health information described in the authorization. Please note, under some circumstances, you may be denied access to your records. If you are a parent or legal guardian of a minor, certain portions of the minor's medical record may not be accessible to you.
- I understand that this information is confidential and is protected within the bounds of HIPAA from disclosure without my permission.
- I understand that released information may be subject to redisclosure by others and may then no longer be protected.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release.

*By typing your name below, you acknowledge and agree this serves as your electronic signature.

_____ _____ _____
Client Signature (14 and older) Printed Name Date

_____ _____ _____ _____
Parent or Legal Guardian Printed Name Relationship Date
(For all clients under 18; co-signature required for clients 14-17)

_____ _____ _____ _____
Parent or Legal Guardian Printed Name Relationship Date
(For all clients under 18; co-signature required for clients 14-17)

_____ _____
Amy R. Paul LPC PC Date
As of: 3-19-2025