Dorothy Hughes, MS, NCC, LMHC
Licensed Mental Health Counselor (IN License 39000908A)
Level III Reiki Practitioner
8465 Keystone Crossing, Suite 208, Indianapolis, IN 46240
765- 237 - 7652 djhugheslmhc@yahoo.com http://dorothyjhughes.com/

Medical Record Release Form

Client Name: _____ Date of Birth: _____

By signing this form, when completed and signed by you, authorizes me to receive and to release protected health information from your clinical record to and from the person you designate below, in verbal or written format.

The information you may release subject to this signed release form for this contact is limited as follows (Check all that apply):

_ _ I am a client of yours. **Required for telehealth client's emergency contact.**
_ _ Complete record
_ _ Treatment Plan
_ _ Progress Notes
_ _ Other: _____

I am requesting my counselor to receive or release this information for the following purpose(s). Please check all that apply.

_____ At the request of the individual. *Please know that if you select, "at the request of the individual" contact must be initiated by your contact listed, not initiated by your counselor.*
_____ In an emergency. **This is required for telehealth clients.** *List someone who you would want to speak to emergency personnel on your behalf in the event you are incapacitated.*
_____ Coordination of services
_ _ Other: _____
_____
_____

Release my protected health information as designated above to the following:

Name: _____ Address _____
Phone: _____ Relationship: _____

This authorization shall remain in effect for a period of one hundred and eighty (180) days unless the authorization is for insurance purposes, in which case it shall remain valid for one (1) year.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Dorothy Hughes's office address. However, the revocation will not be effective to the extent that action has 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 information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and is no longer protected by the HIPAA Privacy Rule.

I hereby state that I fully understand the terms of this release.

_____ _____
Client Signature **Phone**

Address:_____

Date: _____