CHAT N RELAX COUNSELING & CONSULTATION, LLC
DaRon Stephens, LPC, LCADC, LMT
1130 State Route 34, Suite 4, Aberdeen, NJ 07747
(P) 201-675-1083

RELEASE/AUTHORIZATION DISCLOSURE

Client's Name: _____ DOB: _____

I, _____(Print), **give permission to DaRon Stephens, LPC, LCADC, LMT of Chat N Relax Counseling & Consultation, LLC**, to release, disclose, and/or use my (PHI) protected health information & exchange information between **Chat N Relax Counseling & Consultation, LLC** and**:**

Person/Business/Organization:

_____

_____

Phone: _____Ext_____ Email: _____@_____

Fax: _____

Release/Disclose the following: (Please Check)

- □ My (PHI) Protected Health Information regarding ___ counseling ___ massage services
- □ Treatment verification/summary
- □ Progress of treatment
- □ Diagnosis
- □ Urine Analysis Results
- □ Dates of attendance
- □ Coordination of care **via** ___ Telephone ___ Fax ___ Email
- □ Psychological test & evaluations
- □ Discharge summary
- □ Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)

- □ Other or Specific disclosure: _____

Purpose for disclosure:

- □ **I acknowledge this authorization expires, 1 year (12 months), from date signed below unless otherwise specified by this date, no more than 1 year_____.**
- □ I acknowledge that my PHI (Personal Health Information) is confidential and protected by HIPAA (Health Insurance Portability & Accountability Act). I understand that **CHAT N RELAX COUNSELING & CONSULTATION, LLC** cannot & will not disclose, release, and/or report any portion of my PHI (42 CFR Part 2) to any agency, person, business, or entity without signing a release of disclosure as required by law.
- □ I may revoke this release/authorization **in writing,** without explanation, at any time prior to expiration date.

_____ _____
Signature of client **or** guardian if minor (Date)

_____ _____
DaRon Stephens, LPC, LCADC, LMT (Date)