



CHAT N RELAX COUNSELING & CONSULTATION, LLC  
 DaRon Stephens, LMHC, MCAP  
 FLORIDA  
 (P) 201-675-1083

**RELEASE/AUTHORIZATION DISCLOSURE**

Client's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_ (Print), give permission to **DaRon Stephens, LMHC, MCAP 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, LMHC, MCAP

\_\_\_\_\_  
 (Date)