LUMA COUNSELING, LLC
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RELEASE OF INFORMATION

1. Client's Name:_____ DOB:_____

2. Information to be released :
___Summary of treatment to date
___ Report
___Entire medical record
Other: _____

3. Purpose of Disclosure
___Coordination of Care
Other:_____

4. Persons authorized to make Disclosure:
_____

5. Person authorized to receive Disclosure:
_____

6. Method of Disclosure
Written : _____
Verbal:_____
Electronic: _____

7. Today's date:_____Authorization to expire on: _____

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand the risk attached to sharing this information, and/or have discussed risk and benefit with my counselor and accept liability for any and all risk associated with disclosure. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Printed Name of Client: _____

Signature of Client:_____

Date:_____