CORNERSTONE COUNSELING OF ASHLAND, LLC

502 Claremont Ave., Ashland, Ohio, 44805 – Phone: 419.289.1876 Fax: 419.281.6430

Authorization for Use or Disclosure of Protected Health Information

Print Name ______________________________ DOB ______________

I hereby authorize Cornerstone Counseling of Ashland (check one):

- ☐ To Disclose To: ______________________________
- ☐ To Disclose and Receive From: ______________________________
- ☐ To Request From: ______________________________

(Full Name/Title, Address of Person/Agency)

The following information (check all that apply):

☐ **Full Clinical Records** ☐ **Diagnosis** ☐ **Assessment Results (including Test Results)**

☐ **Treatment Plan** ☐ **Summary of Treatment Participation** ☐ **Discharge Summary**

☐ **Other (specify)** ______________________________

Purpose(s) or Need(s) for disclosure and/or receipt of protected health information:

____

Expiration Date: This consent (unless revoked) expires:
- ☐ 90 days from date of authorization listed below
- ☐ other (specify) ______________________________

Statement of Understanding

1. I understand that the protected health information used and/or disclosed based upon this authorization may be re-disclosed to additional parties and no longer protected.
2. I understand that I may revoke or cancel this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office. I further understand that doing so does not apply to the extent that persons authorized to use or disclose my health information have already acted upon this authorization.
3. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.
4. I understand that I have the right to inspect and to obtain a copy of any protected health information disclosed pursuant to this authorization.

______________________________ Date______________

Signature of (**circle one**): Client / Parent / Guardian / Personal Representative

______________________________ Date______________

Signature of witness/title

Revocation: I hereby revoke this authorization. I understand that revocation does not apply to the extent that those authorized to use or disclose my information have already acted in reliance on this authorization.

______________________________ ______________

Signature Date