Steamboat Springs Therapy LLC

William Hambleton Bishop
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Authorization to Request and/or Release Information

I, ______________________________________ hereby authorize William Hambleton Bishop, LMFT, LPC to disclose and/or obtain my health information as described in this authorization.

[1] Specific person(s)/organization to whom William Hambleton Bishop, MA, LPC is authorized to disclose the information:

____

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[2] Specific description of the information to be disclosed by William Hambleton Bishop, MA, LPC:

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[3] I am requesting that my Personal Health Information be disclosed for the following purpose:

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***Right to Revoke**:* I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to William Hambleton Bishop, MA, LPC. I further understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

Expiration: Unless sooner revoked, this consent expires on the following date: _______________ or as otherwise indicated:____

Conditions: I understand that I am under no obligation to sign this form. I acknowledge that I am voluntarily signing this form to release my health information to the party or parties I have designated. I further understand that William Hambleton Bishop, MA, LPC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: ____
____

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Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

***Redisclosure*:** I understand that after this information is disclosed, federal law might not protect it, and the recipient might redisclose it.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

Right to Copy: I understand that I am entitled to receive a copy of this authorization for my records.

Photocopy or Facsimile: A photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.

I have had the opportunity to review and understand the contents of this form. By signing this form, I am confirming it accurately reflects my wishes.

____

Signature of Client Date

____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, parent, etc.)

_____Check here if client refuses to sign authorization

____

Signature of Witness Date