



Authorization to Release Information

This form is used to release your protected health and employment information as required by federal and state privacy laws. Your authorization allows Pro Heights Consultants, Inc. to release your protected health and employment information to a person or organization that you choose and/or to receive information from individuals or organizations that you choose. You can revoke this authorization at any time by submitting a request in writing to Pro Heights Consultants, Inc. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Member Information: (individual whose information will be released)

Name: _____ **Date of Birth:** _____
(First, Middle, Last, Title) (Month/Day/Year)

Address: _____
(Street Address) (City, State) (Zip code)

Telephone Number: _____ **Cell Phone Number:** _____

Email address: _____ **Alternate Email Address:** _____

State License Number: (List all states that you are licensed in) _____

Authorization: (individual and/or organization that will release your information)

I authorize _____ to release my protected health information, employment records, information relating to the practice of my profession, information related to the provision of services and other collected information regarding my contract.

Recipient: (person or organization that will receive your information)

Person's Name or Organization: _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone Number: _____ **Fax Number:** _____

Description of Information to be Released: (Type of Information to be Released)

Employment notes _____ (Initials) **Treatment/Counseling** _____ (Initials) **Genetic Information** _____ (Initials)

HIV/AIDS _____ (Initials) **Substance/Alcohol Abuse** _____ (Initials) **Mental/Behavioral Health** _____ (Initials)

Specific information described below. *

Examples: All information relating to my hospital stay, all treatment records, employer information, etc.

Purpose of Release: _____

Examples: At my request, to assist with my professional contract, etc.

Expiration: (when this authorization will end) this authorization will expire on ___/___/___ (mm/dd/yyyy)
OR on the receipt of written notice revoking this Authorization to Release Information.

Approval: I understand that this authorization for release of information is voluntary. _____ (Initials)

Verification: I verify that I have received the HIPAA information. _____ (Initials)

Signature: By signing below I verify that I have read and understand this Authorization to Release Information.

Signature

Date