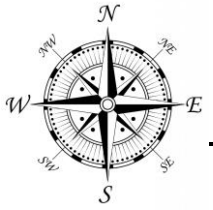

Comprehensive Counseling Connections, PLLC

Authorization to obtain and/or release health information

Comprehensive Counseling Connections, PLLC is herby authorized to:

Obtain □ Provide □ Exchange with □

Name:_____

Address: _____ City: _____

State:_____ Zip code: _____

Phone number: _____ Fax Number: _____

Date(s) of service(s)requested:_____
All protected health information regarding:

Patient's name: _____ DOB: _____

Please check ALL that apply

□ All □ Verbal/Telephone Information □ Progress Notes □ Medical Records
□ Psychological/Neurological Testing Records □ Medication List

A copy or facsimile of this authorization shall have the same force as the original. This authorization is valid for one year from the date of signature or until _____.
I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patients records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may revoke my consent earlier, this consent will expire automatically as follows:_____. [date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent] I will not be denied services if I refuse to consent to a disclosure for other purpose.
This Authorization does not extend to HIV test results_____. [initials]
I have been provided a copy of this form_____. [initials]
I understand that I can revoke this release at any time in writing; however, my revocation would not cover action already taken on the basis of this authorization. I further authorize the delivery of this release document to its intended recipient via U.S. Mail or fax.

Signature: _____ Date_____

Parent/Legal guardian signature_____

Name of CCC Provider(s)_____