Eunice Aviles, PsyD, LMHC, LPC
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Authorization to Use and Disclose Protected Health Information

Person served information

Legal Name: _____ DOB: _____

Release from Eunice Aviles, PsyD, LMHC, LPC

I authorize Eunice Aviles, PsyD, LMHC, LPC to release and disclose health information to, and allow such information to be inspected and copied by:

Person/Facility/Provider: _____

Address: _____

Dates of services:_____ Nature of information to be disclosed: _____

Purpose of information to be disclosed (check all that apply):

__ Facilitate care __ Legal __Request of person served __Other:_____

Release to Eunice Aviles, PsyD, LMHC, LPC

I authorize (Person/Facility/Provider): _____

Address: _____

to release and disclose health information to Eunice Aviles, PsyD, LMHC, LPC.

Dates of services:_____ Nature of information to be disclosed: _____

Purpose of information to be disclosed (check all that apply):

__ Facilitate care __ Legal __Request of person served __Other:_____

Release of privileged information

I understand that my record may include statutorily protected information as describe below. I approve the release of this information unless the" __do not release" line is checked:

Do not release (mark all that apply):

__ Alcohol and/or drug abuse diagnosis or treatment
__Behavioral/Mental Health diagnosis or treatment
__Sexual assault counseling
__Sexually transmitted diseases
__Domestic violence counseling
__Psychotherapy notes

Release of HIV/AIDS information

I authorize the release of my health care information pertaining to HIV and/or AIDS related diagnosis and/or treatment: __Yes ___No

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Eunice Aviles, PsyD, LMHC, LPC. I understand that a revocation is not valid to the extent that Eunice Aviles, PsyD, LMHC, LPC has acted in reliance on such authorization.

This authorization is valid until _____.

I understand that Eunice Aviles, PsyD, LMHC, LPC cannot guarantee that the recipient will not re-disclose my health information to anyone else.

A copy of this release shall have the same force and effect as the original.

_____ _____

(Client's signature or Parent/Guardian's signature) (Date)