Authorization for Use or Disclosure of Protected Health Information (PHI)

From/To: Name of Individual/Organization Disclosing/Receiving Protected Health Information	
Name: All Inclusive Counseling, Inc. Leilani Keator MA LMFT	Address: 5540 N Academy Blvd Suite 210 Colorado Springs, CO 80918 Fax: 719-264-7697, Ph:719-632-5033 allinclusivecounseling.com
From/To: Name of Individual/Organization That Will Receive/Disclose the Individual's Protected Health Information	
Name:	Address:
Client/Patient Whose protected Health Information is Being Requested	
First Name:	Last Name:
Address:	Birth Date (if known):

I Authorize that the Following Protected Health Information be Used/Disclosed: (Be specific. Identify limits, as appropriate. Initial in the space provided if your authorization includes the use/disclosure of specially protected health information)
Verbal and/or written formatted information or records related to evaluation, treatment, progress, discharge planning, recommendations, referrals and all other records related to mental, emotional, or behavioral health. **(Initial whichever applies**): _____ Mental Health _____ Substance Abuse Treatment _____ HIV/AIDS
The Protected Health Information is Being Used or Disclosed for the Following Purposes (*At the request of the Individual* is an acceptable purpose if the request is made by the individual and the individual does not want to state a specific purpose.):
At the request of the individual to coordinate services between specified individuals, to provide collaborative comprehensive evaluation, and determine and provide appropriate coordinated care with continuity.
Authorization Duration (This authorization will be in force and effect until the date ***or*** event specified below. At that time, this authorization to use or disclose this protected health information expires)

Authorization Expiration Date:	Expiration Event That Relates to the Individual or the Purpose of the Use or Disclosure: Annual expiration or completion of treatment.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Leilani Keator MA LMFT. I understand that a revocation is not effective to the extent that Leilani Keator MA LMFT has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA, 34 CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or re-disclosed without my authorization.

The Entity or Person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to Leilani Keator MA LMFT from a Third Party.

Individual or Personal Representative Signature:	Date:
Printed Name of Individual or Personal Representative:	Description of Personal Representative's Authority: