The Stress Therapist, LLC
Authorization for Release of Information

Please fill out this form only if you would like The Stress Therapist, LLC to release or receive information or records with another health care professional

Pursuant to the Health Insurance Portability Accountability Act of 1996, The Stress Therapist, LLC can only accept request(s) for release of information that include specific HIPAA compliant requirements. This signed authorization will be required for each and every record request and will be date, time and request specific. We can no longer accept blanket release of records forms. Please complete the following:

This is to authorize The Stress Therapist, LLC to:

RELEASE AND RECEIVE (circle one or both)

Such information regarding the treatment of: ________________________

Please list below the specific dates of service or specific information requested:__

____

____

Specific purpose of this release: ____

____

This specific information shall be:

EXCHANGED BETWEEN: Cheri Augustine Flake, LCSW (The Stress Therapist, LLC) and: ____

____

____

RECEIVED from: ____

____

____

and/or RELEASED to: ____

____

____

Expiration date of this authorization: ______________________

Please initial here that it is ok to communicate via mobile phone: ______________

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

____ ________________

Signature of client or person authorized to consent Date

____ ________________

Witness Date