Counseling4Life

REQUEST FOR RECORDS FOR CLINICAL DOCUMENTATION AND TREATMENT RECORDS + AUTHORIZATION TO RELEASE AND RECEIVE PHI

This form is to be completed and signed as a formal and written request for the release of clinical documentation and treatment records. This request form provides information to COUNSELING4LIFE, LLC about the specific nature of the request, along with the proper authorization, that allows COUNSELING4LIFE, LLC to properly execute the release of sensitive client information appropriately and safely. Please complete all areas below:

Part I: Understanding the Nature of Your Request

Client Name for which records are being requested:

Other names used by Client in the past:

Client's Date of Birth:

Person (Phone and Email) completing this request:

Purpose for requesting the client's records:

Name of Recipient of these records?

Check which to INCLUDE in this records request:

- ❑ Billing Record
- ❑ Treatment Plan
- ❑ Evaluation Reports
- ❑ Entire Record
- ❑ ALL Progress Notes
- ❑ or special Dates (Intake Note is included):
- ❑ Special Date(s) of Service being requested:

How should the Recipient receive the records?

- ❑ Email
- ❑ Fax
- ❑ Mailing Address

Name, Ph., Fax, Email, and Address of Recipient:

Other considerations to fill this request:

Part II: Record Request Policies and Fees

COUNSELING4LIFE, LLC'S policies regarding requests for Clinical Documentation and Treatment Records are listed below:

COUNSELING4LIFE, LLC does not provide counseling nor release records or information for legal purposes or personal situations that could lead to legal cases (i.e., divorce, custody determinations, termination of parental rights, adoption, guardianship, or disability cases), for the purpose of evaluations or expert testimony, and must be deemed therapeutically appropriate to disclose on behalf of the client. IF this request is for this purpose, it will subject to the fees noted in the "FORMS, LETTERS, & REPORTS" and "LEGAL SITUATIONS" section on our website Insurance & Fees page.
COUNSELING4LIFE, LLC keeps client records to reflect the session start/stop times, modalities and frequencies of treatment furnished, diagnosis, functional status, supplemental diagnostic information, correspondence regarding client's care, treatment plan, symptoms, and progress

notes, a brief summary of the content of your sessions (not a reflection of the therapist's opinion of you/your situation). Records or aspects of records will only be released when deemed therapeutically appropriate to disclose on behalf of the client.
Upon written receipt of the request for records, the client will be prompted to complete this form, will be notified of the estimate for the fee for COUNSELING4LIFE, LLC to furnish the requested records and of any other information needed to properly fulfill this request. COUNSELING4LIFE, LLC shall furnish records within 15 days after the date of the receipt of this request and the fee for furnishing the records is received (which includes an estimated postage fee of $15, in the event that these records will be mailed). Notary services will be subject to an additional $20 flat fee.

COUNSELING4LIFE, LLC fees for Request for Clinical Documentation, Treatment Records, Reports, Summaries of Treatment, or Letters by and to clients are: $30 per request records, letter, form, or per page of clinical summary, plus any reasonably estimated postage fees required to expedite documentation requested. Follow-up requests for records (to accompany initial requests) are $5 per request.

COUNSELING4LIFE, LLC requires a proper Authorization for Release of Information signed and dated by the client, parent/legal guardian(s) or personal representative, which identifies the records to be disclosed and the person or entity to who the records are to be disclosed, to accompany any request for records.

COUNSELING4LIFE, LLC is required to redact protected health information about another person, not the client, in the records, to protect the third person's privacy and confidentiality and privilege of the person's information, unless consent from the third person has been obtained.

COUNSELING4LIFE, LLC allows a client or other person authorized to consent to the release of records to withdraw the consent to release information at any time by providing written notification that the authorization is revoked.

COUNSELING4LIFE, LLC will be unable to retract any release of records or information that was made in good faith, prior to obtaining written notice that the authorization was revoked.

Part III: Authorization to Release PHI

I hereby authorize COUNSELING4LIFE, LLC, and/or my COUNSELING4LIFE, LLC Counselor to disclose and receive protected and individually identifiable health information (PHI) as described below, which may include psychotherapy notes.

I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment for my health care will not be affected if I do not sign this form.

I also understand that if I do not sign this form, federal and state law will prohibit, COUNSELING4LIFE, LLC, and/or my COUNSELING4LIFE, LLC Counselor, from releasing the charts, notes, and knowledge of treatment of me or my minor child to the designated recipients.

By accepting the records pursuant to this Authorization, the Recipient acknowledges that the protected health information covered by this authorization is confidential, privileged, and protected by federal and state privacy statutes and regulations, and agrees that COUNSELING4LIFE, LLC'S and/or my COUNSELING4LIFE, LLC Counselor's release and receipt of the individually identifiable health information will continue to be protected by federal and state privacy statutes and regulations.

Description of information to be released and received: (check all that apply):

- ❑ Diagnosis
- ❑ Treatment Plan
- ❑ Billing Records
- ❑ Entire Records
- ❑ Special Psychotherapy Notes Date(s) of Service
- ❑ I deny permission for this Authorization.

Psychotherapy Notes - Dates of service (if known):

The individually identifiable health information described herein shall be released to and/or received from:

Name, Address, Phone, Email/Fax:

Section for spouse | partner | family member *(Complete only if the client's spouse/ partner/family member was a participant in treatment; signature of participating party in treatment is required).*

Spouse/partner/family member's First, Last Name:

Spouse/partner/family member's DOB:

Part IV: Authorization for the Electronic Disclosure of PHI

For this request to be complete, this form must also accompany a completed and signed AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION Developed for Texas Health & Safety Code § 181.154(d) form (available at www.counseling4lifellc.com or provided by our office with this form) which authorizes for the electronic disclosure of PHI (Protected Health Information) of the named client in this request for clinical documentation and treatment records.

Part V: Acknowledgment and Consent

By electronically signing below, I, the undersigned client(s), acknowledge that I have been informed of the terms of the this agreement, and agree to abide by its terms, and conditions and I also intend for this authorization to remain in full force until I revoke it in writing, to be sent to COUNSELING4LIFE, LLC at 16607 BLANCO RD, STE 1404 SAN ANTONIO, TX 78232.

The revocation will not affect any actions taken before the receipt of the written revocation, including if this authorization was obtained as a condition of payment and if the financially responsible party has a legal right to contest a claim. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.

Client/Client Representative Signature

Relationship to Client

Date

[For spouse | partner | family member]

Signature of spouse/ partner/family member who was a participant in treatment in which records are being requested.

Relationship to Client

Date

COUNSELING4LIFE, LLC
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