**Drew Prochniak, MA, LPC, LMHC**
2256 N Albina, #177
Portland, OR 97227

P: 503.308.9408
F: 888.972.9148
www.dprochniak.com

**HEALTH INFORMATION RELEASE FORM**

This form represents your consent and authorization for the parties below to use, disclose, and receive medical and mental health information pertaining to either ☐yourself ☐your child (check one).

*I,* **(PRINT CLIENT NAME)** _____, *hereby authorize* __Drew Prochniak, MA, LPC, LMHC__ *to disclose information and records obtained in the course of my diagnosis and treatment for the following purposes:*

- ☐ to increase understanding of my previous history
- ☐ diagnosis and treatment
- ☐ to coordinate care on an ongoing basis with other providers that are also treating me
- ☐ to discuss my care with family or friends that may be important sources of support.

**This information may be shared/ obtained or provided in the following way(s):**

- ☐ verbal
- ☐ electronic
- ☐ hard copy

**Information is to be disclosed to the following parties:**

| INDIVIDUAL OR ORGANIZATION | ADDRESS | PHONE AND FAX NUMBER |
|---|---|---|
| | | |
| | | |
| | | |

*I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by __Drew Prochniak, MA, LPC, LMHC__ to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation. I understand that I have the right to refuse consent and signing of this authorization and that __Drew Prochniak, MA, LPC, LMHC__ shall not condition my treatment or the treatment of those under my care upon this refusal. I understand that I am voluntarily signing this form to release my (or my child's) health information to the party or parties designated. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information. This authorization is effective immediately and shall remain in effect for one year from date of signing unless explicitly revoked in writing.*

**SIGNATURE** _____ **Date** _____

**If parent or legal guardian, please print your name here** _____
**Relationship to patient:** ☐Self ☐Parent ☐Guardian