Alliance Counseling
Jean Allbee-Roberson LMFT LLC
495 Gold Star Hwy, Ste 108, Groton, CT 06340
Tel (860) 861-1453 Fax (860) 245-4248
www.RobersonLMFT.com

Authorization for Release of Protected Health Information

I understand that Alliance Counseling has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Alliance Counseling to release some of my personal information to certain individuals or agencies.

I, _____ DOB: _____, authorize Alliance Counseling

☐ to release/ ☐ to obtain the following specific information to/from:

Name(s):_____
Agency:_____
Address:_____
Phone Number:_____ Fax Number:_____

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail

☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

What info about me can be shared:	☐ Entire Record ☐ Information related to:_____ _____ ☐ Alcohol/Drug Abuse Treatment ☐ HIV/AIDS-related Treatment ☐ STDs ☐ Mental Health (other than psychotherapy notes) ☐ Psychotherapy Notes
Why I want my info shared: (purpose)	

I understand:

☐ That I do not have to sign a release form. I do not have to allow Alliance Counseling to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like Alliance Counseling to release information about me in the future, I will need to sign another written, time-limited release.

☐ That Alliance Counseling and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be share it with others.

This release expires on: _____
Date

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Signed:_____ **Date:**_____ **Witness:**_____

Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)

I confirm that this release is still valid, and I would like to extend the release until _____
New Date

Signed:_____ **Date:**_____ **Witness:**_____