EVOLVING REFLECTIONS

Authorization to Release Confidential Information

☐ I authorize Evolving Reflections to release information to the person(s)/organization(s) listed below:

Organization/Medical Provider/School	Phone	Fax
Address	City	State/Zip

☐ I authorize Evolving Reflections to obtain information from the person(s)/organization(s) listed below:

Organization/Medical Provider/School	Phone	Fax
Address	City	State/Zip

Client Name: _____ Date of Birth: _____

Provider: _____

Parent/Guardian Name: _____

Address: _____ City: _____ State/Zip: _____

Specific Information to be released:

☐ Identifying Information	☐ Medical Information	☐ Therapy Notes
☐ Billing Records	☐ Diagnostic Information	☐ Phone Consults
☐ Complete Medical Record	☐ Substance Information	☐ Other: _____

I authorize the release of these records through facsimile and/or email. I understand and agree that should the records be in advertently transmitted to an unauthorized recipient, through no fault of the

Evolving Reflections
7473 W. Lake Mead Blvd. Suite 100
Las Vegas, Nevada 89128
Phone: (702) 850-2833 Fax: (702) 938-6205

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sender, I hereby waive any claim against the sender and agree to hold the sender harmless from any and all responsibility of damages, if any, arising from the faulty transmission.

This authorization is in effect until termination or 12 months from the date below. I understand that I may change my mind at any time and revoke this authorization by notifying Evolving Reflections in meriting. I understand that changing my mind or refusing to sign this form will not affect my treatment. I understand that I have the right to inspect or copy any information disclosed under this authorization. I understand that once my health information is disclosed to the recipient, Evolving Reflections cannot guarantee that the recipient will not disclose the health information to a third party or as required by law. I have read and understand this authorization and had a chance to ask questions about the disclosure of health information. I authorize Evolving Reflections to disclose any health information in the manner described above.

_____ _____

Signature Date

_____ _____

Parent/Guardian Signature Date

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