



"Creating Life Balance Through Effective Solutions"

# Release of Information

I, \_\_\_\_\_ DOB: \_\_\_\_\_  
Authorize Lisa Stull, MS, LMFT to obtain information from, and share information with:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Information may include: (check to include)

- Mental Health Assessment and Diagnosis
- Service Plans and Session Notes
- Medical Information/Medications Prescribed
- Other: \_\_\_\_\_
- Treatment Summary and Recommendations
- Drug/Alcohol History/Treatment/UA Results
- Psychological Testing/Consultation

I understand that information to be released/authorized may include information regarding the following condition(s): (check to include)

- Drug Abuse
- Psychiatric Conditions/Treatment
- HIV/AIDS
- Alcoholism or Alcohol Abuse

I understand that if this is a **Release** for "Treatment, Operations and Payment" purposes, Lisa Stull, MS, LMFT may withhold treatment, payment enrollment or eligibility for benefits if I refuse to sign. I understand that if this is an **Authorization** for "Other" purposes, Lisa Stull, MS, LMFT, may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign or not. The purpose for which information is to be authorized/released is:

- Treatment, operations, or payment (If checked this form becomes a **Release** and services can be refused if consumer refuses to sign)
- Other [e.g. Law (attorneys, probation), Education (schools) or Social Services] (If checked this form becomes an **Authorization** and under HIPPA rules services may not be conditioned or refused if consumer refuses to sign.)

If the information to be released/authorized pertains to the diagnosis and treatment of alcoholism and drug abuse I understand that the confidentiality of the information is protected by Federal Law 42.C.F.R. Part 2. I understand that there is potential for information disclosed, as a result of this Release/Authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPPA Privacy Regulation.

I understand that I may revoke this Release/Authorization at any time by giving written notice to Lisa Stull, MS, LMFT, except to the extent that action has already been taken to comply with it. Without such revocation, this release/authorization will expire one year from date signed unless other wise indicated: \_\_\_\_\_. I understand that I have a right to refuse to sign this form subject to the conditions noted above or if I sign I am entitled to a copy of the signed form.

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains.

*A copy/facsimile of this Release/Authorization is as valid as the original.*

\_\_\_\_\_  
Signature of Consumer/Parent/Legal Representative

\_\_\_\_\_  
Relationship to Consumer

\_\_\_\_\_  
Lisa Stull, MS, LMFT

\_\_\_\_\_  
Date

Lisa Stull, MS, LMFT