SUZANNE M ELTON LPC LMHC

Doctoral Candidate Depth Psychology

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Patient Authorization for Disclosure of PHI (Personal Health Information) RELEASE OF MEDICAL RECORDS and/or consent to consult:

I, ____, agree that Suzanne Elton LPC may consult with

___________________________________ of _______________________and/or send a copy of my medical records.

I would like the following released:
______ Dates and charges of service.
______ A summary of my sessions and treatment.
______ My entire record.
______ Other (explain)
____
Date of Birth: ____
Phone Number: ____

I understand that if I have any questions about my clinical records, or the content within, I can contact Suzanne Elton and someone will meet with me to discuss my records.
I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 ('HIPAA'), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that that any notice to revoke consent must be in writing.

Signature: _______________________________________ Date: ________________________