# Authorization to Release Information

Client Name _______________________________ Date of Birth____________________

Mantis Counseling and Coaching Services, LLC is authorized to disclose my Protected Health Information as specified below to the following person or organization:

Name ____________________________________ Phone number __________________

Organization ________________________________________________________________

Address ___________________________________________________________________

Information to be provided:

_______ Mental health records and diagnosis information

_______ Psychological testing

_______Information regarding medical conditions and current prescriptions

_______ Other: ___________________________________________________________

Purpose or need for the information being requested
___________________________________________________________________________
___________________________________________________________________________

This authorization will expire in one year from the date signed below unless another date is listed.
___________________________________________________________________________

I understand that I may revoke this authorization at any time in writing to the address listed above. I understand that any revocation can only apply to future disclosures or actions regarding disclosures of my information and cannot cancel actions taken or disclosures made while the authorization was in effect.

I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. A copy of this authorization is as effective as the original.

Client Signature _________________________________ Date ____________________
(Parent or legal guardian may sign on behalf of a minor child.)

## Authorization to Receive Information

Client Name _______________________________ Date of Birth___________________

The following person or organization is authorized to disclose my Protected Health Information as specified below to Mantis Counseling and Coaching Services, LLC:

Name ____________________________________ Phone number _________________

Organization _______________________________________________________________

Address ___________________________________________________________________

Information to be provided:

_______ Mental health records and diagnosis information

_______ Psychological testing

_______Information regarding medical conditions and current prescriptions

_______ Other: ___________________________________________________________

Purpose or need for the information being requested

__________________________________________________________________________

__________________________________________________________________________

This authorization will expire in one year from the date signed below unless another date is listed.

__________________________________________________________________________

I understand that I may revoke this authorization at any time in writing to the address listed above. I understand that any revocation can only apply to future disclosures or actions regarding disclosures of my information and cannot cancel actions taken or disclosures made while the authorization was in effect.

I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. A copy of this authorization is as effective as the original.

Client Signature _________________________________ Date ___________________

(Parent or legal guardian may sign on behalf of a minor child.)