Ostermiller Counseling Services Inc.

242 East 7th North, Suite 4

Rexburg, ID 83440

(208)359-9683

Fax (208)359-0889

RELEASE OF INFORMATION

Authorization for Disclosure of Protected Information

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Ostermiller Counseling Services Inc.

(*check either box or both, as needed)* [ ] to release information to: [ ] to obtain information from:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Organization)

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(Contact information {address, phone number, etc.})

Protected health information to be used or disclosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The protected information is being used or disclosed for the following purposes:

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I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Jared Ostermiller, Privacy Officer, at 242 East 7th North, Suite 4 Rexburg, ID 83440.

I understand that a revocation is not in effect to the extent that Ostermiller Counseling Services Inc. has relied on the use or disclosure of the protected health information. I understand that this consent expires 12 months from date of signature unless otherwise specified.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

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Signature of Patient or Legal Guardian Date