AUTHORIZATION FOR RELEASE OF INFORMATION

I. Information About the Use or Disclosure:

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.*

Client Name: _____ Last 4 digits of SSN: _____

Persons/Organizations/Doctors authorized to provide the information *(name, address, phone#)*:

- _____
  _____
- _____
  _____
- _____
  _____
- _____
  _____

Persons/organizations authorized to receive the information:

Christian Counseling Center, LLC
Attn: _____
2585 S. Jones Blvd., Suite 2F, Las Vegas, NV 89149 **Office: (702) 248-4547**
1337 Camino Del Mar, Del Mar, CA 92014 **Office: (858) 356-8256**

Specific description of information to be used or disclosed (including date(s)):

_____
_____
_____
_____
_____

Specific purpose of the disclosure:

_____
_____
_____
_____
_____

This authorization will expire _____ *(indicate date, or an event relating to you personally or to the purpose of the authorization).*

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.

- I may see and copy the information described on this form if I ask for it.

- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

III. Signature of Patient or Patient's Representative

Printed Name: _____

Signature: _____ _____
Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

Phone number of patient or personal representative: (____)_____

Printed name of the patient's personal representative: _____

Relationship to the patient, including authority for status as representative:

Please return one copy of completed form to:

Christian Counseling Center, LLC
2585 S. Jones Blvd., Suite 2F, Las Vegas, NV 89149 Office: (702) 248-4547
1337 Camino Del Mar Blvd., Suite B, Del Mar, CA 92014 Office: (858) 356-8256