Practice Locations in Coeur d'Alene, ID and Williamsburg, VA
Phone: (757) 645-7722, Fax: (757) 645-2808
www.safeharborcounselingcenter.com

CONSENT TO RECEIVE AND RELEASE INFORMATION

This consent applies to: ____ DOB: _____________________________
Client Name Client's Date of Birth

I, _______________________________________ (client or parent/legal guardian), hereby give my informed consent for Lisa Frazier, LPC, LMFT and Safe Harbor Counseling Center, LLC to communicate with and release written, verbal, and electronic documentation regarding my or my child's treatment (client name listed above) to the following individuals or providers:

____
Name of Person, Provider, and/or Organization; Address, Phone and Fax numbers if applicable

Information I authorize to be discussed or released:
___ My Entire Record ___ My Entire Clinical Record (not billing or financial information)
___ Only the Following: ____

I understand that my records are protected under the Federal HIPPA Laws and under the general laws of my state and cannot be re-disclosed without written consent, except as specifically stated by law.

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that according to the Code of Virginia, Safe Harbor Counseling Center, LLC is allowed up to 15 business days to process my request for copies of my medical record.

I understand that according to the Code of Idaho, Safe Harbor Counseling Center, LLC is allowed up to 30 days to process my request for copies of my medical record.

I understand that there will be a charge of $25 for processing of documented requests, plus 25 cents per page for supplies, and that all charges must be paid in full before my records are released.

I understand that under Federal law the above named individual may release information from my record without my consent under the following circumstances:

1. Suspected child or elderly abuse
2. Indication that an individual is a danger to self or others
3. Subpoena/ court ordered records

I understand that consent to receive and release information is valid as of the date of signature below and for a period of 12 months, unless otherwise indicated.

I understand that I may revoke my authorization to release information at any time in writing and such revocation will be effective on the date of receipt of my revocation. In the event action already has been taken prior to said receipt of revocation, such prior actions are covered by the pre-existing release.

I understand that this authorization is voluntary and I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

____ ___________________
Client or Parent/Legal Guardian Signature Date

____ ___________________
Witness Signature Date

Practice Locations: 206 Ironwood Dr. #1012, Coeur d'Alene, ID 83814
1320 Richmond Rd. #1053, Williamsburg, VA 23185