Twila Meyer, MA, LPC-S

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
FROM TWILA MEYER, MA, LPC-S

I, ____, hereby authorize
(Name of patient or legal representative)

Twila Meyer to disclose the following information by _____mail _____fax ______orally to:

Name: ____
(Name of person/entity who should receive records)

Address: ____
(Address of person/entity who should receive records)

City, State, Zip Code: ____

Phone Number: ______________________________ Fax Number: ____________________________

From the health records of:

____ D.O.B _________________
(Name of person whose records will be disclosed)

My authorization extends only to those date elements/documents marked below:

______ All Health Information
______ Statements of Charges or Payments
______ Progress Notes
______ Record of visit for specific date ____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. Twila Meyer and staff are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
6. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

____ __________________________
Patient/Legal Representative Signature Date