Main Street Counseling, LLC
1286 Jungerman Road
St. Peters, MO 63376
636-498-0700

Continuity And Coordination Of Care Authorization Form For Release Of Health Information

Name of Client: _____
Last First Middle Maiden or Other Name

Date of Birth: _____ Phone Number: _____

I hereby authorize Cindy Eisenbeis, MSW LCSW to release my medical/health information to:

Name: _____

Address: _____
Street City State Zip

Phone Number: _____ Fax Number: _____

Medical/Health Information to be Released

I authorize the release of the following specified information:

	Date of Authorization
o Entire Medical/Health Record	_____
o Progress Reports	_____
o Substance Abuse Information (including Alcohol/Drug Abuse)	_____
o HIV/AIDS related Information	_____

This authorization is made for the following purpose(s):

o At my request	_____
o Specify Purpose: _____	_____
o Referral to Other Professionals	_____
o Consultation with Other Professionals	_____

CONDITIONS OF AUTHORIZATION

1. This authorization is valid for 6 months from today's date: _____
2. I may revoke this Authorization at any time by notifying Cindy Eisenbeis,MSW LCSW in writing. It will be effective on the notification date except to the extent that Cindy Eisenbeis, MSW LCSW has already acted upon such authorization.
3. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
4. By authorizing this Release of Information, my healthcare and payment for my healthcare will not be affected if I do not sign this Authorization form.
5. I have been offered a copy of this signed Authorization form.

_____ _____

Signature Of Client (Or Parent/Legal Guardian Or Other Authorized Person) **Date**