

Choices Counseling & Resource Center, P.A.

Request for Listing of Disclosures of Client Records

The purpose of this form is to request a listing of disclosures of client records made by Choices Counseling & Resource Center, P. A. for a client. It does not include routine requests such as billing, treatment, or typical clinic operations. Disclosures prior to 4-14-03 are not available.

Client

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

Your relationship to client: Self Parent/legal guardian Legal representative
 Other (describe) _____

Dates of requests for listing of disclosures you are requesting:

All

From _____ to _____

I authorize the above request.

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's Signature: _____ Date: ____/____/____

Parent/guardian/legal representative (if applicable)

Signature: _____ Date: ____/____/____

Witness (if client is unable to sign)

Signature: _____ Date: ____/____/____