**HIPAA COMPLIANT CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**
**Pursuant to 45 CFR 164.508**

Name: ________________________________ Birthdate: ______________________

Address: ______________________________________________________________

I hereby authorize Lombino Counseling LLC to disclose my personal health information and all documentation that are requested on this consent form to the designee identified below:

Name: ______________________________ Address: ____________________________

Phone: ______________________________ Fax: _______________________________

Specific information and documents to be released relating to, among other things, mental health and/or alcohol/substance use:

Initial:
_______Phone Consultation
_______Intake and Assessment
_______Treatment Plans
_______Progress Notes
_______Other medical records as follows: ______________________________________

Purpose of release: _______________________________________________________

Restrictions of release, if any: ______________________________________________

My signature indicates that I have read this form, know exactly what information is being disclosed, and have had the chance to correct and change the information to make sure it is correct and complete. I am aware that this consent can be revoked in writing at any time. I have received a copy of this consent for my records. This consent ends one year from the date signed unless revoked by me in writing before that time. This consent is effective immediately.

________________________________ ______________________________
Signature of Consenting/Releasing party Signature of Witness

____________________
Date