Lauren Hoyt, LLC
520-543-1700
Lauren@lhoyttherapy.com

AUTHORIZATION TO RELEASE INFORMATION

Name: _____ DOB: _____

I authorize Lauren Hoyt, LMFT, LISAC to

☐ release information to ☐ obtain information from ☐ exchange information with

Name/Agency: _____

Address: _____

Telephone #: _____ Email:_____

Information is limited to:

☐ Complete behavioral health record (Excludes substance abuse treatment)
☐ Assessments/Test results
☐ Treatment Plans
☐ None
☐ Progress notes
☐ Dates of attendance/appts not kept
☐ Summary of treatment
☐ Substance abuse treatment (Initials_____)
☐ Other _____

Disclosure of information is for the purpose of:

☐ Coordination of care with another mental health professional
☐ Coordination of care with another health professional
☐ Resolution of a legal matter
☐ Other _____

If I am seen in couples counseling, I have been advised that under the Arizona Administrative Code R4-6-1105(E), both partners must provide consent to release couples counseling records. If one or the other of us does not provide consent, records will not be released.

I understand that as a result of my request for my Protected Health Information, I cannot hold Ms. Hoyt or Lauren Hoyt, LLC responsible for any actions taken by any other individual. If my request is for my PHI to be released to me, I understand that it is my responsibility to protect my own privacy by keeping the released information in a secure place and in my possession. If my request is for my PHI to be released to another individual or entity, I understand that the information that will be exchanged includes records in any form, as well as discussion, with the individual or entity authorized above. I understand that I can revoke this authorization at any time by simply making that request in writing to Lauren@lhoyttherapy.com or PO Box 78 Flat Rock, MI., 48134.

My authorization will expire one year from today or _____(whichever date is sooner).

Signature: _____ Date: _____

Witness (if necessary): _____ Date: _____