

Country Counseling, LLC

970-286-7856
www.countrycounselingllc.com

832 W. Eisenhower Blvd, Suite E
Loveland, CO 80537



Consent for the Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

I hereby authorize Country Counseling, LLC and its clinicians and staff to:

Release Receive Information To/From:

Contact Name/Facility: _____

Address: _____

City, _____

State _____

Zip _____

Phone: _____ Email: _____

My primary therapist and main contact individual at Country Counseling, LLC is Kathy Korell-Rach, Ph.D. She may be reached by calling 970-286-7856 or emailing kkorellrach@gmail.com

Information to be disclosed includes:

- Payment/Billing
- Treatment Plan
- Treatment Summary
- Coordination of Care
- Other: _____

Information may be disclosed via:

- USPS/FedEx/UPS mail
- Telephone
- Electronic methods (including email)
- Other: _____

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 "HIPAA" 45 C.F.R. parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

Patient Signature

Date

Expires: Date: _____ or Conclusion of treatment

*This is a strictly confidential patient medical record and protected by HIPAA.
Redisclosure or transfer is expressly prohibited by law.*