

# 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](mailto: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.*