Authorization for Release of Protected Health Information

Anxiety Alliance Counseling, LLC
13911 Ridgedale Dr. Suite 240
Minnetonka, MN 55305
Phone: 952-545-2249 • Fax: 952-516-5115

Client Name: _____ Date of Birth: _____
(Please print)

I, the above named client, give Barbara J. Benson, MA, LPC of Anxiety Alliance Counseling, permission to:

☐ Exchange information with: ☐ Request information from: ☐ Send information to:

Name of Person or Provider: _____

Address: _____

Phone: _____

Fax: _____

The purpose of the disclosure is:

☐ Collaborative care

☐ Continued care

☐ Other reason (specify): _____

The information to be disclosed is:

☐ All information regarding assessment, diagnosis, and treatment

☐ Other information (specify): _____

This authorization will expire one year from the date below.

I authorize the release of my confidential protected health information, as described in the directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. I have been offered the document PATIENT RIGHTS AND HIPAA AUTHORIZATIONS.

Signature: _____ Date: _____

If client is a minor, please indicate signer's relationship to client: _____/

Modified 4/10/24