



Thrive Counseling LLC
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**Patient Authorization for Disclosure of PHI (Personal Health Information)
RELEASE OF MEDICAL RECORDS**

I, _____, wish to obtain a copy of my medical records.

Reason I am requesting my records: _____

I would like my records sent to: _____

I would like the following released:

____ Dates and charges of service.

____ A summary of my sessions and treatment.

____ My entire record.

____ Other (explain) _____

Social Security Number: _____

Date of Birth: _____

Phone Number: _____

I understand that if I have any questions about my clinical records, or the content within, I can contact Thrive Counseling and someone will meet with me to discuss my records.

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 ('HIPAA'), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that that any notice to revoke consent must be in writing.

Signature: _____

Date: _____