Blueprint Counseling Solutions
A Marriage & Family Therapy Corporation
PO Box 2083, La Mesa, CA 91943-2083
619.844.1345 (office)/ 619.354.7193 (fax)

Patient Name :_____
Date of Birth: _____/_____/_____ Social Security Number: _____
Address: _____
Street City, State Zip Code

E-mail Address: _____ Phone: _____

I request that Blueprint Counseling Solutions □ Obtain □ Disclose my protected health information (PHI) with:
Recipient Name: _____
Address:_____
Phone: _____ Fax: _____ Email: _____

I authorize the following PHI to be released from my medical record(s):

□ Assessments
□ Psychotherapy Notes
□ Treatment Plan
□ Treatment Summary
□ Discharge Summary
□ Substance Use
□ Evaluations
□ Billing Statements
□ Attendance/ Participation Summary
□ Progress Report
□ Other (Specify): _____

The authorized disclosure of PHI herein is required for the purpose(s) of:

□ Coordination and Continuity of Care
□ Legal Use
□ Personal Use
□ Insurance/ Billing
□ Disability
□ Treatment Planning
□ School
□ Research
□ Other (Specify): _____

I authorize Blueprint Counseling Solutions to release/ obtain the information marked above. Blueprint Counseling Solutions will not withhold treatment or insurance payment based on whether I sign this form. I have the right to a copy of this form, and to inspect or obtain a copy of the health information disclosed. Records released may include information received from other organizations. Records released may no longer be protected by law and could be re-disclosed by the recipient. This authorization will be valid for 1 year from the date of my signature, unless a date is otherwise specified. □Other (Specify):
_____

I may revoke this authorization by providing a written* request to Blueprint Counseling Solutions. The revocation will take effect upon receipt. *(A photocopy/fax of this authorization will be treated in the same way as an original.) There may be a charge for records (0.25 cents per page).

_____ _____
Patient Signature (Client/ Legal Guardian/ Conservator) Date