LIVE HAPPY COUNSELING

9488 FLAMINGO RD. #102 LAS VEGAS, NV 89147 (T) 702 665 5593 (F) 702 665 5887

Patient Name: _____ Social Security #: _____

Date of Birth: _____ Phone Number: _____

Address: _____

STANDARD AUTHORIZATION OF USE, DISCLOSURE OF AND RECORDS RELEASE REQUEST OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed:

□ All Medical Records- including verbal conversations
□ Specific Records: _____
□ Verbal Conversations Only

NAME OF ORGANZATION/ PHYSICIAN	ADDRESS	PHONE/ FAX NUMBER

Persons to Whom information indicated above will be disclosed to the following FAMILY members or FRIENDS.

NAME	RELATIONSHIP	PHONE NUMBER

Expiration Date of Authorization: This Authorization is effective for one year unless revoked or terminated by the patient or the patient's authorized representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a WRITTEN revocation to Live Happy Counseling.

Potential for Redisclosure (release): Information's that is disclosed (released) under this authorization may be disclosed again by a person or organization to which it is sent or given to.

PRINT NAME OF PATIENT	PATIENT SIGNATURE DATE
PRINT NAME OF A REPRESENTAIVE/ GUARDIAN	**AUTHORIZED REPRESENTAIVE SIGNATURE DATE**