Elana Sabajon & Associates, PLLC
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Release of Information

I request that Elana Sabajon, MA, LMHC disclose my private health information as specified below. The nature of the information to be disclosed is (check all that apply):

- ☐ my entire treatment record
- ☐ information relevant for coordination of care
- ☐ billing information
- ☐ scheduling information

- ☐ other _____

The information to be disclosed specifically **does** include (check all that apply):

- ☐ psychotherapy notes
- ☐ substance use disorder counseling session notes

The information specified above will be disclosed to:

Name _____

Institutional/Agency Affiliation_____

Unless an alternative expiration date or event is specified here, this authorization will expire 90 days after the date of my signature below. _____ (alternative expiration date or event)

I understand that my protected health information disclosed pursuant to this agreement may be subject to redisclosure by the recipient and in such cases may no longer be protected by state or federal rules of confidentiality.

I understand that I have the right to refuse to sign this form for authorization to disclose or release my private health information and that my refusal to sign this authorization will not adversely affect my ability to receive health care services, nor will treatment, payment, enrollment or eligibility for benefits be conditioned on whether I sign this authorization.

I understand that I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed as described in this authorization unless action has already been taken in reliance on this authorization.

This authorization is being made at my request.

_____ _____
Client Signature Date

_____
Print Client Name