STEARNS MUSIC THERAPY, LLC
315 W. Dodds St. * Bloomington, IN 47403 * (812) 320-2679

Consent for Release of Information

Client's Name: ____________________ Date of Birth: _____ / _____ / _____

Address: ____

City/State/Zip: ____

1. Authorization
I authorize Stearns Music Therapy to use and disclose the protected health information described below to the following parties:

1. Name: ______________________________ Phone: (____) _____ - __________

   Agency/Organization: ____

   Address: ____

   Email: ______________________________

2. Name: ______________________________ Phone: (____) _____ - __________

   Agency/Organization: ____

   Address: ____

   Email: ______________________________

3. Name: ______________________________ Phone: (____) _____ - __________

   Agency/Organization: ____

   Address: ____

   Email: ______________________________

4. Name: ______________________________ Phone: (____) _____ - __________

   Agency/Organization: ____

   Address: ____

   Email: ______________________________

2. Effective Period
This auhorization for release of information covers the period of healthcare from:

a. [ ] _______________ to _________________

OR

b. all past, present, and future periods

3. Extent of Authorization
a. [ ] I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. [ ] I authorize the release of my complete health record with the exception of the following information
- [ ] mental healthcare
- [ ] communicable diseases (including HIV and AIDS)
- [ ] Alcohol/drug abuse treatment
- [ ] Other (please specify): ____

4. This clinical and medical information may be used by the person I authorize to receive this information for clinical or medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until ____________________ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that my health information may be protected by the Federal Rules (HIPPA) for privacy of Individually Identifiable Health Information, but that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Client/Parent/Legal Guardian Signature: ______________________

Printed Client Name: ______________________

Printed Parent/Legal Guardian Name: ______________________

Date: ______________________