A&R COUNSELING SERVICES LLC

Authorization to Disclose Protected Health Information

I hereby authorize A&R Counseling Services LLC (Neal Bobal MA, LPC) [ ] Disclose [ ] Receive [ ] Both	
A&R Counseling Services LLC **Att: Neal Bobal MA, LPC** **47 MARCHWOOD RD** **SUITE 2A-5** **EXTON PA, 19341** **Phone: (610) 314-6530** **arcounseling4u@gmail.com** **www.arcounseling4u.com**	Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____-_____ Fax: ( ) _____-_____

Information to be disclosed by A&R Counseling Services LLC

[ ] Entire file	[ ] Symptoms	[ ] Diagnosis
[ ] Session notes	[ ] Prognosis	[ ] Progress to date
[ ] D&A	[ ] HIV	[ ] Other

Information requested

[ ] Entire file	[ ] Symptoms	[ ] Diagnosis
[ ] Session notes	[ ] Prognosis	[ ] Progress to date
[ ] D&A	[ ] HIV	[ ] Medications

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time. I also understand that such revocation must be in writing and received by Provider to be effective.

I authorize the disclosure of the health information described above for the following purpose:

_____

_____

Effective Date: _____/_____/_____ to _____/_____/_____

Patient: _____ Date: _____/_____/_____

Therapist: _____ Date: _____/_____/_____