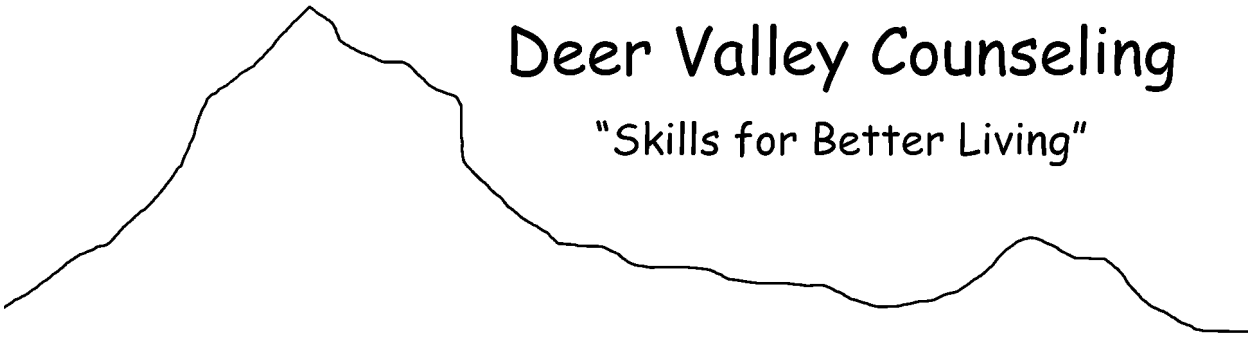

Authorization for Release of Confidential Information When Someone Else Is Paying for My Sessions

I, _____ Date of Birth of Client: _____
(Client's Name or Person Authorized to Sign for Client)

hereby authorize Deer Valley Counseling to release information to the following person or organization:

_____
(Person/Organization) (Telephone Number)

_____
(Address) (City) (Zip)

I understand that the purpose of the disclosure is to keep the person or other entity paying for my appointments informed of whether a charge is for attendance or a no-show.

The information to be disclosed is whether a specific charge to the payer is for an appointment or a no-show, and the date of that appointment or no-show.

I understand that I may revoke, in writing, this authorization at any time, except to the extent that action has already been taken in reliance on it. I understand that this information may be redisclosed by the recipient and at that time would no longer be protected by the originator. I understand that Deer Valley Counseling may not condition services upon my signing this authorization unless the services are provided to me for the purpose of creating health information for a third party. If I refuse to sign this authorization, I may still receive services from Deer Valley Counseling but must pay for them myself. This authorization for release of information will expire on _____ (if left blank, one year from the date it was signed).

_____	_____	_____
Printed name of Client	Signature of Client	Date Signed
_____	_____	_____
Person Authorized to Sign for Client	Signature of Person Authorized to Sign	Date Signed

Reason person may sign for client: ☐ Parent ☐ Guardian ☐ Other: _____

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