**True Self Counseling**

**Cristina Morue, MC, LPC, NCC**

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**AUTHORIZATION FORM**

*This form, when completed and signed by you, authorizes Cristina Morue, MC, LPC, NCC to release and/or request protected health information from your clinical record to the person you designate.*

\_\_ Psychological Exam and or Testing Result \_\_ Medical Record

\_\_ Treatment Summary \_\_ Psychotherapy Notes   
\_\_ Telephone Contact/Consultation \_\_ Diagnosis

\_\_ Oral Communication

**This Information Should Only Be Released To or From:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization shall remain in effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or one year from the date signed.

***You have the right to revoke this authorization, in writing, at any time by sending such written notification to Cristina Morue, LPC. However, your revocation will not be effective to the extent that Cristina Morue, LPC has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.***

***I understand that Cristina Morue, LPC as my psychotherapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.***

***I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.***

**Signature of Self, Parent, or Guardian:**

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Signature Printed Name Date Signed***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Signature Printed Name Date Signed***

*If the authorization is signed by a personal representative of the patient, a description of such representative’s authority to act for the patient must be provided.*