VERA COUNSELING COLLECTIVE, PLLC

Authorization to Release or Exchange Information

This form allows Vera to share, receive, or exchange information as directed below.

Effective July 2026

CLIENT INFORMATION

Client name		**Date of birth**	
Phone		**Email**	

PERSON OR ORGANIZATION

Name / organization		**Contact person**	
Phone		**Fax**	
Email		**Address**	

Authorization

I authorize Vera Counseling Collective to:

- ☐ Release information
- ☐ Receive information
- ☐ Exchange information
- ☐ In both directions

Date range:

- ☐ From _____ to _____

OR

- ☐ Entire treatment period

Purpose:

- ☐ Coordination of care
- ☐ Insurance/payment
- ☐ At my request
- ☐ Other: _____

Information that may be shared

- ☐ Assessment/intake
- ☐ Diagnosis and symptoms
- ☐ Treatment plan and goals
- ☐ Progress/treatment summary
- ☐ Attendance
- ☐ Medication information
- ☐ Billing/insurance information
- ☐ Discharge summary
- ☐ Verbal consultation only
- ☐ Other: _____

Expiration

This authorization expires:

- ☐ One year from the date signed
- ☐ On this date/event:

_____

Important limits

Psychotherapy notes and federally protected substance-use-disorder records are not included unless separately authorized as required by law.

Your rights

You may revoke this authorization in writing at any time, except to the extent action has already been taken. Signing is voluntary and generally will not affect treatment, payment, enrollment, or eligibility for benefits. Information disclosed may be redisclosed by the recipient and may no longer be protected by HIPAA. You may request a copy of this signed form

Client name

Date of birth

Client, parent, legal guardian, or financially responsible party signature

Date

Relationship to client

Questions or revocation requests: hello@veracounselingcollective.com | (623) 252-6140