Full of Heart

Authorization to Release Information

I understand that Full of Heart Counseling & Consultation has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Full of Heart Counseling & Consultation to release some of my personal information to certain individuals or agencies for the purpose of coordinating care. In context of my therapeutic relationship with Full of Heart, I authorize my therapist, _____, to contact the following health care professional that I am currently working with as it pertains to our therapeutic relationship.

Client's Legal Name: _____

Date of Birth: _____ Social Security Number: _____

I hereby authorize Full of Heart Counseling & Consultation to (initial all applicable):

_____ obtain relevant treatment information from the following provider

_____ release relevant treatment information to the following provider

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

the following documents/information from the records pertaining to services received

Dates of Service: _____

The documents to be released are to include only information pertinent to the coordination of care for the above client and can be described or listed as: *(specify information allowed to be shared)*

_____

_____

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail

☐ *I understand that electronic mail is not confidential and can be intercepted and read by other people.*

I understand that my authorization will remain effective for one year from the date of my signature and that the information will be handled confidentially in compliance with Full of Heart policy and all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

_____ _____

Client/Guardian Signature Date

_____ _____

Witness Date

Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)

I confirm that this release is still valid, and I would like to extend the release until _____ _____
New Date New Time

Signed:_____ **Date:**_____ **Witness:**_____