

Judy Hu Counseling

CONSENT to DISCLOSURE of INFORMATION and RECORDS

I, _____ (Date of Birth: _____)

hereby authorize _____ to release my records and reports relating to my appointments beginning with my first appointment on _____. This information is to be given to: _____; for the following purpose, use or need:

- Coordination of treatment
- Provision of information to other professionals
- Other _____

The following information from my records may be disclosed:

- General Protected Health Information (PHI) (Demographic data, dates of service, diagnosis, psychological evaluation, treatment plan, global assessment of treatment progress)
- Psychotherapy Notes
- Verbal Exchange of PHI

I understand that this authorization may be withdrawn by me at anytime. Revocation of this authorization will not affect any information already released. I hereby certify that I am 18 years of age or older. Unless this form is previously revoked in writing, this release of information will remain in force until six (6) months from date of signature.

| | |
|---------------------|------|
| Signature of Client | Date |
| Witness | Date |

Consent By Person Other Than Client

If client is under 18 years of age or otherwise unable to consent, the following must be completed:

I, _____ hereby certify that I am the _____ of the client; that the client is unable to consent because he/she is a minor, _____ years of age or because: _____.

| | |
|-------------------------------------|------|
| Signature of Parent, Guardian, etc. | Date |
| Witness | Date |