Release of Information

Date: **Name:** **Date of birth:**
Phone Number: **Email Address:**

I, the undersigned, hereby authorize Gissa Hernandez, LCSW at Grateful Insights, LLC, to release information as described below:

Information to be Released:

☐ Progress notes
☐ Assessment reports
☐ Treatment plans
☐ Other (specify):

Purpose of Disclosure:

☐ Coordination of care
☐ School-related purposes
☐ Referral to another provider
☐ Insurance purposes
☐ Legal purposes
☐ Other (please specify):

Recipient of Information:

Name of Individual or Entity Receiving the Information:
Address: Phone Number:
Email Address (if applicable):

Expiration of Authorization:

This authorization will expire on or upon the completion of the purpose described above. If no date is provided, the authorization will remain in effect for one year from the date of signing, unless revoked earlier by the client in writing.

Right to Revoke:

I understand that I have the right to revoke this authorization at any time by providing written notice to Gissa Hernandez, LCSW at Grateful Insights, LLC. However, the revocation will not apply to information that has already been released in accordance with this authorization.

Voluntary Nature of Authorization:

I understand that I am not required to sign this authorization to receive treatment. I also understand that my decision to sign or not sign will not affect my right to receive services.

Confidentiality:

I understand that the information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. Gissa Hernandez, LCSW and Grateful Insights, LLC are not responsible for the recipient's use or disclosure of the information once it has been released.

Signature and Date:

By signing below, I acknowledge that I have read and understand the contents of this Release of Information form. I consent to the release of my information as described above.

Printed name of client: Date:

X

Client signature

By typing your name above, you acknowledge and agree that this constitutes your electronic signature.

Date:

X

Therapist signature