## Jasper Counseling Associates

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## **Release of Information**

Name of Patient:		
	is hereby authorized to release to and/or recei	ve from:
the following documents and/or in Notification of Initial Contact General Treatment Information	nformation (please check all that apply):	
Periodic Progress and Evaluation Re	eports	
Attendance Reports Any information useful in treatment p Other:	planning and/or coordinating treatment	
notification your therapist listed above should you request it, will not be effe on the previously granted authorization	thorization in writing at any time by sending such we. Be advised that the revocation of this authoriz ective to the extent that I may have taken action in tion to release information or in the event that this ndition of your seeking to obtain insurance coverage the claim.	ation, reliance prior
	ices is not generally contingent upon my signing an unless the services are provided to me for the pured and party.	
I hereby release	from any and all liabilities, responsibilitarise from the release of information as indicated a slid for: 30 days 60 days 30 days specify):	bove. I
	or disclosed pursuant to the authorization may be so your information and no longer protected by the HIF	
Client's signature:	Date:	_
Client's representative:(if client is a minor)	Date:	
Witnessed:	Date:	_

Notice to Receiving Agency or Individual

This information has been disclosed to you from records whose confidentiality is protected by federal law (42 CFR Part 2/37 CFR 1401) and in compliance with Section 408 of Public Law 92-255 (21 USC 1175). You are prohibited from making any further disclosure without the specific written consent of the person(s) to whom it pertains or as otherwise permitted by such regulations.