AUTHORIZATION TO RELEASE INFORMATION

_____ (Name of agency releasing protected client information)	_____ (Name of person and/or agency to receive information)
_____ (Street Address)	_____ (Street Address)
_____ (City, State, Zip Code)	_____ (City, State, Zip Code)
_____ (Phone) (Fax)	_____ (Phone) (Fax)

Specific description of information to be disclosed *(please check either Y for Yes or N for No for EACH category)*:	
☐ Y ☐ N Discharge or Treatment Summary	☐ Y ☐ N Social History
☐ Y ☐ N Dates of Treatment	☐ Y ☐ N Treatment Plans
☐ Y ☐ N Medical/Physical History	☐ Y ☐ N Medication History
☐ Y ☐ N Psychiatric Evaluation	☐ Y ☐ N Billing and Payment Records
☐ Y ☐ N Educational Records	Other Information (specify):

REASON FOR RELEASE OF INFORMATION: ☐ Coordination/Continuity of Care ☐ Other_____

DATE(S) OF SERVICE COVERED BY THIS REQUEST:_____

VOLUNTARY: I know that I am not required to sign this consent form and that I will not be refused treatment if I do not sign this form. I can refuse to sign this consent form, although disallowing collaboration between involved parties may limit the quality of services I receive from any of the agencies.

LENGTH OF TIME: This consent will be valid from the date that I sign this form until _____ (date). If no date is entered, the form will be valid until *the date that I terminate services* with Prospering Hope Counseling, PLLC ("the Clinic").

WITHDRAWAL OF CONSENT: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written notice to the person or agency asked to release this information. The withdrawal will be valid as soon as the person or agency receives my notice, but will not apply to information that has already been shared after I signed the consent form and before receipt of the withdrawal notice.

SHARING OF INFORMATION: I know that my information may be shared more than once by the persons and/or agency(ies) listed above. The information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other State and Federal laws. The Clinic is not responsible for further release of information by other agencies.

COPY: A copy of this consent form may serve as the original. I know that I have a right to obtain a copy of this consent form if I request one.

My signature below indicates that I have read and understand this document.

Print/Type Name: _____ Telephone: _____

Complete Address: _____

SSN#: _____ Date of Birth: _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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