Breaking Barriers Therapy Center, LLC.
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RELEASE OF INFORMATION FORM

I, _____, hereby authorize Flora Williams M.A., LMFT-t, owner of Breaking Barriers Therapy Center, LLC, to release verbal and/or written information to:

_____ _____ _____
Full name of person or entity Phone Fax

_____
Address

For the following purposes:
□ Treatment and assessment □ Coordination of care □ Referral of new or additional services

□Other_____

Specific information to be released includes:
□ Assessment and diagnosis □ Treatment goals □ Session Content □ Discharge

□ Other: _____

I understand that by signing this General Authorization I am authorizing Breaking Barriers Therapy Center, LLC to disclose my health information to the persons and entities listed above and that any health information or other confidential information in the possession of the persons and entities listed above may be disclosed to Breaking Barriers Therapy Center, LLC.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Breaking Barriers Therapy Center, LLC. I understand that my revocation of this General Authorization will not affect a disclosure that Breaking Barriers Therapy Center, LLC has already made under this authorization. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Breaking Barriers Therapy Center, LLC's confidentiality rules. I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

I understand that signing this is not a condition of receiving services.

This authorization will expire 12 months from the date that πthe document is signed or on the specified date of ____/____/____.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, HIV/AIDS-RELATED INFORMATION AND GENETIC INFORMATION

I understand that this will include information relating to the following categories unless I specifically deny the release.

(INITIAL ANY CATEGORY THAT'S NOT TO BE RELEASED)

____Mental Health ____Substance Abuse ____HIV/AIDS ____Genetic information (test results)

_____	_____	_____
Printed name of Client/Parent /Legal Guardian	Signature	Date
_____	_____	_____
Printed name of Client /Parent/Legal Guardian	Signature	Date
_____	_____	_____
Printed name o fClient/Parent/Legal Guardian	Signature	Date