**Live Life Counseling, LLC**

1435 Haw Creek Circle

Suite 403

Cumming, GA 30041

 ***Release of Information/Authorization Form***

*(Please check all applicable boxes)*

1. ☐ I am completing this form to allow the use and sharing of protected health information about:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name Date of Birth

1. ☐ I authorize Live Life Counseling, LLC administrative staff, and

☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Therapist/Counselor

1. To obtain or disclose the following information:

☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnosis, prognosis, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.

☐ Academic and educational records, including achievement and other test results, reports or teacher’s observations, and all other school or special education documents.

☐ Billing records

☐ Other

1. ☐ To the following or from the following person(s) or organization(s):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ☐ This release will permit my therapist/counselor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to speak directly to the party(s) or organization(s) named in Paragraph 4 concerning my care as provided in Paragraph 3 of this Authorization.
2. ☐ I authorize my therapist/counselor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to testify regarding the provisions of psychological services to me at any disposition or hearing in which I am party.
3. The information will be used/disclosed for the following purposes:

☐ at the request of the individual, or

☐ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ☐ I understand and agree that this Authorization will be valid and in effect until \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_. I understand that after that date no more of this information can be used or released to the person(s) or organization(s) unless I sign a new Authorization.
2. ☐ I understand that I can revoke or cancel this Authorization at any time by sending a letter to Live Life Counseling, LLC If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
3. ☐ I understand that my therapist/counselor generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
4. ☐ I understand that information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.
5. \_\_\_\_\_\_\_\_\_- I understand that this session will be recorded at the SAFFT center and that the SAFFT center will be able to view any session held at this location.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or his/her personal representative Date

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Printed name of patient or personal representative Relationship to Patient

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Description of Personal Representative’s authority