South Point Counseling Services, LLC

Authorization for Release of Information

Client Name:	Client Name:

I authorize the release of my confidential protected health information as described below. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. Upon request, I may revoke this authorization at any time by sending a written notice to South Point Counseling Services. Any disclosures that have been made to the individuals or entities listed below prior to this written notice will not be affected by the revocation.

This authorization will expire on ____/_____/_____ or upon the happening of the following event:

_____

Information to be released:

- ☐ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)
- ☐ Other (describe): _____

Purpose of disclosure: The reason I am authorizing release is:

- ☐ My request
- ☐ Other (describe): _____

Decline to release information:

- ☐ I decline to release information to anyone other than my insurance, if applicable, until a new form is signed updating an authorized person(s) to receive disclosure of my information.

Person(s) authorized to receive the disclosure:

Name		**Telephone**	**Client Initials**
Insurance Company			
Bishop	Address:		
Primary Care Physician (PCP)			
Other:			
Other:			

Client Signature	Date	Client Signature	Date
Parent/guardian (if under 18)	Date	Parent/guardian (if under 18)	Date