INSTRUCTIONS

The form below should to be used if you WANT to release your/your child's information to a third-party. Clients will sometimes release information to a doctor, attorney, another family member, or another third-party. If the client is a child or a minor, any parent/guardian has legal rights to the child's mental health therapy records. Also, you do not need to complete this release of information form to request a copy of your personal therapy records.

<u>You only complete this form if you want to release medical records to someone else as explained above.</u>

South Point Counseling Services, LLC

Empowering individuals, couples, and families

Authorization for Release of Information

Client Name:	Date of Birth:

I authorize South Point Counseling Services (hereinafter "Provider") to disclose/exchange mental health treatment information and clinical records obtained during psychotherapy treatment, including, but not limited to therapist's diagnosis, of the client listed above to:

_____ _____

Name Phone

_____ _____

Address Fax (Secured)

_____

City State Zip

I am requesting this disclosure of information and clinical records for the following purpose:

☐ At the request of the client or guardian ☐ Other: _____

The specific uses and limitations of the types of health information to be released are as follow: (Check all that apply)
A separate authorization, as defined by HIPAA, is required for Psychotherapy Intake and Progress Notes.

☐ Intake and Progress Notes (ONLY) ☐ Psychological Testing Results

☐ Treatment Coordination ☐ Entire Treatment Record except progress notes

☐ Treatment Plans ☐ Other: _____

Such disclosures shall be limited to the following specific types of information: (Check all that apply)

☐ Psychiatric Diagnosis(es) ☐ Initial or Intake Treatment Plan

☐ Dates of Treatment ☐ Other: _____

This authorization will expire automatically after one year.

I understand that I have the right to receive a copy of this document. 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 individual or entity listed above prior to this written notice will not be affected by the revocation. Provider shall not condition treatment upon my signing this authorization, and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information.

_____ _____

Client Signature Date

_____ _____

Signature of Legal Guardian (Relationship to Client) Date