AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION

To:

______________________________________ Date:___________________________

______________________________________ Client:________________________________

______________________________________ Date of Birth:__________________________

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I hereby authorize _______________________________________ at Hope Counseling Center to ____obtain ____release the following protected health information concerning counseling services received by myself or my minor child or legal charge. It is further understood that this authorization is subject to revocation at any time in writing, and unless otherwise specified hereinafter, it automatically expires one year from the signature date.

Specific Information To Be Disclosed: (client must initial each item to be released/obtained)

____ Psychological Evaluations

____ Diagnostic Information

____ Treatment Summaries

____ Medication(s)

____ Statement of Progress

____ Prognosis

____ Discharge Summary

____ Recommendations for Current Therapy

____ Other:____

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my health information and no longer protected by the HIPAA Privacy Rule. I understand all of the aforementioned, and with informed consent and of my own free will, authorize this disclosure of protected heath information.

Richmont Graduate University
Hope Counseling Center
4200 Northside Parkway
Building Four, Suite 100
Atlanta, GA 30327

Signed:______________________________________
Signature of Patient or Parent of Minor or Legal Charge

Witness:____________________________________

Date:____________________