



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

To:

Date: _____

Client: _____

Date of Birth: _____

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)

- | | |
|----------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Statement of Progress |
| <input type="checkbox"/> Diagnostic Information | <input type="checkbox"/> Prognosis |
| <input type="checkbox"/> Treatment Summaries | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Medication(s) | <input type="checkbox"/> Recommendations for Current Therapy |
| <input type="checkbox"/> 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 health 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: _____