THERAPY STUDIOS

create a life you love

AUTHORIZATION TO RELEASE INFORMATION

I, ___________________________, (hereinafter 'Client') hereby authorize ___________________________ (hereinafter 'Provider') to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to Provider's diagnosis of client to the following person/agency:

Name/Agency:
Address:
Phone:
Email:

I understand I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand I have the right to revoke this authorization at any time, unless Provider has already taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider at 5107 North Rhett Avenue, North Charleston, SC, 29405 to be effective.

The disclosure of information and records authorized by client is required for the following purpose:

The specific uses and limitations of the types of medical information to be discussed are as follows:

Such disclosure shall be limited to the following information:

Provider shall not condition treatment upon client signing this authorization and Client has the right to refuse to sign this form. Client understands that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rules, although state law may protect such information.

Client Signature:____Date:____________

Client Printed Name:____

Parent/Guardian Signature:_____________________________________Date:____________

Parent/Guardian Printed Name:____