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Authorization for Release for the use or Disclosure of Confidential Mental Health Information

Client Name: _____ Client DOB: _____

Address: _____ Date of Request: _____

Effective dates of Release: From _____ to _____

As required by the National Privacy Regulations (HIPPA) I, _____ hereby authorize this office, Delta Family Counseling, LLC and any of its employees to use or disclose medical and/or psychiatric information of the client listed above to:

(Name of individual or agency)

(Address)

Information to be disclosed: _____.

I understand that the specific reports disclosed would include:

(Describe specifically)

I understand that the information disclosed above may be re-disclosed to other parties without the knowledge or consent of this office and acknowledge that once disclosure occurs the information is no longer protected.

I understand that I can revoke consent with written notice, except to the extent that action has been taken in reliance upon this authorization, and that I have a right to review all information before it is disclosed. I understand that if I do not sign this document, it will not condition my treatment or payment.

Signature of Client or Parent/Legal Guardian

Date of Authorization

Signature of Witness

Printed Name of Witness