Infinite Hope
COUNSELING

Authorization for Release of Information

Client _____ Date of Birth _____ Social Security Number _____

☐ **REQUEST** I hereby request and authorize the following identified individual, agency, and/or organization to release to Infinite Hope Counseling LLC the specified information identified below.

☐ **RELEASE** I hereby authorize Infinite Hope Counseling LLC to release and disclose the specified information identified below to the following identified individual, agency, and/or organization.

Name of Person or Department _____

Agency/Organization _____

Mailing Address _____

City, State & Zip _____

Telephone Number _____ Fax Number _____

To request from or release to Infinite Hope Counseling LLC the following information:

- ☐ Intake Note
- ☐ Progress Notes/Reports
- ☐ Treatment Plan
- ☐ Diagnosis
- ☐ Prognosis
- ☐ Termination Note/Summary
- ☐ Information relevant to coordinating care
- ☐ Medical History
- ☐ Psychological Evaluation/Report
- ☐ Psychiatric Evaluation/Report
- ☐ Psychosocial Evaluation/Report
- ☐ Educational Record/Report
- ☐ Telephone Consultation
- ☐ Emergency Contact
- ☐ Other _____

The purpose(s) for which information is to be released:

- ☐ Continuity of Care
- ☐ Consultation
- ☐ Referral
- ☐ Other _____

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and federal confidentiality regulations (42 CFR Part 2). The federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as otherwise permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose.

I understand that this authorization is valid until its expiration 12 months from the date signed below. I further understand that I may revoke this authorization in writing at any time, except for actions that have already been taken prior to a revocation request. Infinite Hope Counseling LLC and its authorized representatives are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

Client Signature or Parent/Guardian Signature *(mandatory if client is a minor)* _____ Date _____

Witness Signature _____ Date _____