AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Hence Counseling and Assessment Center to release written and/or verbal records/information to the following agency and/or person:

Name: _____ Agency: _____

Address: _____ Phone: _____

Information/Records to be released in regards to the following person:

( ) Psychological History

( ) Psychological Testing/Evaluation

( ) Therapy Notes

( ) Medical Records

( ) Assessment(s)

( ) Continuity of Care

( ) Other: _____

- If I am signing as a parent or a guardian of a minor, I understand that the records released may contain references to my family and myself.
- The authorization period will continue for one year from the date.
- I understand my rights to confidentiality. I further understand that this consent form gives Hence Counseling Center permission to share confidential information about me and/or my child in the way described above.
- Release of information is voluntarily, I understand I have the right to refuse Hence Counseling Center's request.
- I understand I have the right to revoke this authorization in writing after signing this form.
- I understand that all information will be treated as confidential .

Client/Parent/Guardian: _____ Date: _____

Therapist: _____ Date: _____

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.