COUNSELING SERVICES – AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

CLARITY COUNSELING AND HYPNOTHERAPY, LLC

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Clarity Counseling and Hypnotherapy, LLC and the persons or entities listed below, or their representatives, to mutually release and disclose my health information.

I understand that by signing this *General Authorization*, I am authorizing Clarity Counseling and Hypnotherapy, LLC to disclose my health information to the persons and entities listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to Clarity Counseling and Hypnotherapy, LLC. My health information includes, without limitation, any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational or psychological condition. Disclosure may also be made to describe my condition and progress and to discuss treatment.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Clarity Counseling and Hypnotherapy, LLC office where I am receiving counseling. I understand that my revocation of this *General Authorization* will not affect a disclosure that Clarity Counseling and Hypnotherapy, LLC has already made under this authorization.

I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by Clarity Counseling and Hypnotherapy, LLC’s confidentiality rules.

I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

This authorization is only valid until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (fill in date), or until three months after my file is closed at Clarity Counseling and Hypnotherapy, LLC.

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| Primary Insurance Company | Address | | Client’s Initials |
| Secondary Insurance Company | Address | | Client’s Initials |
| Bishop/Pastor | Address/Phone | | Client’s Initials |
| Name and Relationship | Address/Phone | | Client’s Initials |
| Name and Relationship | Address/Phone | | Client’s Initials |
| Name and Relationship | Address/Phone | | Client’s Initials |
| Name and Relationship | Address/Phone | | Client’s Initials |
| SIGNATURES | | | |
| Client’s Signature | Date | Client’s Signature | Date |
| Name of parent of guardian (if client is under 18) |  | Name of parent of guardian (if client is under 18) |  |
| Signature of parent of guardian (if client is under 18) | Date | Signature of parent of guardian (if client is under 18) | Date |
| Witness | Date | Witness | Date |