AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name:____***DOB:***______________________

I authorize the exchange of information to and/or from **True Joy Counseling and Consulting, PLLC** and

Heath Center/School/Organization Name/Person: (If name of contact person is known, also place it below)
Name: ____
Address: ____
Phone: ____Fax______________________________________

Type of Information to Release/Disclose:
☐ All Records ☐ Medical/Hospital Records ☐Treatment Plans ☐ Diagnosis ☐ Mental Health Summary
☐ Psychotherapy Notes *(by checking this box I am waiving any psychotherapist-patient privilege)*
☐ Psychological/Medical Testing ☐Course of Treatment
☐ Other:____

The Purpose of Release/Disclosure:
☐ Ongoing Treatment ☐Coordination of Care ☐Family/Support System Integration ☐ Consultation
☐ Legal ☐ Evaluation ☐ Health Benefit Utilization ☐ Transfer ☐Other:_______________________________
☐ Specific Exceptions____

This consent remains in effect until ____________________. I understand that I may revoke this authorization, in writing at any time, unless action based on it has already taken place.
The designated information about me may be transmitted by fax, other electronic file transfer mechanisms, or discussed by telephone by the authorized individual and/or practice designated above. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed psychotherapists, except as provided in Florida Statutes Section 491.0147 and in certain legal exceptions. In general, these exceptions pertain to matters of danger to self and others, or to prevent the potential abuse or neglect of vulnerable populations. I further understand that the potential exists for disclosure in proceedings or actions by other parties subsequent to the information release authorize and may not be protected under the HIPAA regulations.

This is to certify that I have given consent freely and voluntarily, and the benefits and disadvantages of releasing the information are known to me.

Signature ______________________________**Print Name** ____________________________**Date** ____________
(Patient, Parent, Guardian, or Personal Representative)

*****This form must be notarized if not signed and submitted in front of a True Joy Counseling & Consulting Representative.*****

State of ____________________County of___________________.
This authorization was acknowledged before me
on this ________day of _______________________, __________. *(Notary Seal)*
Signature of Notary Public____________________________
Notary Printed Name________________________________