

Consent for Release of Confidential Information

I authorize Elizabeth M. Atkinson, LPC to release to and/or to obtain from the following:
In Person, Fax, Letter or by Phone

Person(s) _____

Organization(s) _____

Address _____

City _____ State _____ Zip _____ Phone _____

The following information:

_____ Progress Notes/Report	_____ Psychological Testing
_____ Treatment Plan	_____ Medications/Medical History
_____ Contents of File	_____ Other _____

I understand that my records are protected under the federal and state confidentiality regulations, and cannot be released without my written consent unless otherwise provided for in said regulations. I also understand that I may revoke this consent at any time in writing unless action has already been taken based upon it and that in many events this consent expires automatically in twelve months.

By signing below, I hereby release the above parties from any and all liability resulting from the release of this information.

Client/Patient (print) _____ Date of Birth _____

Signature of Client _____ Date _____

Parent/Guardian* _____ Date _____

Counselor _____ Date _____

*Parents/Guardians please note: 18 year old patients may request by their own will to sign a written authorization a release granting me permission to share confidential counseling information with the person(s) of their choice, including parents, guardians and other clinicians. (Hipa Privacy Act 1996). 2.5.3 Parent's Requests 2.5.3a Parents do not have a right to their child's PHI if the child is 18 years and older and is competent. 2.5.3b If parents call without a signed Authorization, staff should tell the parent that PHI of their child cannot be released without a an Authorization from the child. If there is an Authorization for release of an Individual's PHI to the Individual's parent, the staff may release the PHI. Exception: Except for the situations specified in 2.d.i - v, above, PHI will be provided to the parent or legal guardian of a patient under the age of 18.