Healing Journey Counseling Services, LLC

Help on the journey to healing, wholeness and tranquility.

Phone: 404-800-4048 Fax: 706-645-3550

Release of Information-Client Disclosure Authorization

I, ______________________________________, hereby authorize the release and disclosure of the following clinical and/or protected health information for the following purpose(s):

[ ] Authorization to release information regarding counseling and therapy care and treatment.

[ ] Authorization to release information held under the Drug Office and Treatment Act of 1972 (PL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974.

[ ] Authorization to release information related to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Please release exchange of authorized information between **Healing Journey Counseling Services, LLC** and:

____

Specific information to be released (check all that apply):

_________ Assessments & Evaluations _________ Psychological History

_________ Continued Care & Treatment _________ Discharge Summary

_________ Progress or Participation _________ Program Administration

Purpose(s) for which information is to be released: [ ] Program Administration

[]Other____

Disclosure will be by the following method(s): (Check all that apply) _______FAX ______ WRITTEN ______VERBAL _______ AUDIO TAPES _______VIDEO TAPES ________ELECTRONIC

Revocation/Expiration: This Release of Information is subject to revocation by the under-signed at any time except to the extent that information has already been disclosed based on authorization contained herein or if this authorization was obtained as a condition of obtaining insurance coverage. Unless further limited by a dated stated here, ______________, this Release of Information will automatically expire after a period of 180 days from the date signed. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient an no longer be protected by HIPAA privacy rules. Healing Journey Counseling Services, LLC of West point, GA will not condition treatment on my providing authorization for the requested use or disclosure. I have the right to access my protected health information to be used or disclosed. I have the right to receive a copy of this Release of Information upon my request.

Client/Guardian____Date:___________

Witness____Date:___________