Cherokee Counseling & Psychological Associates, L.L.P.
8910 Main St., Woodstock GA 30188-4916
Ph: 770-924-1818 – Fax: 770-928-5731

CONSENT & AUTHORIZATION TO RELEASE INFORMATION

Patient's full name: _____

This form when completed and signed by you, authorizes me to release or receive protected information from your clinical record to/from the person(s) you designate.

I, _____ (patient/parent/guardian), hereby authorize _____ (therapist) to release and/or receive my private health information to/from:

(1) _____

(2) _____

The above party or parties may discuss my mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnosis:

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my medical and/or mental health information without limitations.

____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows:

_____

I acknowledge that this consent is valid for sixty (60) days or until _____.

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Additionally, the above named parties, therapist & person(s) or entity (entities) designated under (1) or (2), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named therapist at Therapist's Address to be effective.

Client's Signature: _____ Date: _____

Parent's/Legal Guardian's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

This information has been disclosed to you from records whose confidentiality is protected by federal law (42 CFR Part 2/37 CFR 1401) and in compliance with Section 408 of Public Law 92-255 (21 USC 1175). You are prohibited from making any further disclosure without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.