Authorization to Release Information

Stephanie Hefner, MA

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I, (name of patient) _____(hereinafter "Patient") hereby authorize Stephanie Hefner, LMHC, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of counseling treatment of Patient, including, but not limited to, counselor's diagnosis of Patient to: _____

I understand that I have the right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider Stephanie Hefner, LMHC to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose: _____

_____

Counselor shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Florida law may protect such information.

This authorization shall remain valid until _____

Patient's signature: _____Date: _____