HOPE In Home Counseling, LLC
PO Box 49014
St. Petersburg, FL 33743-9014
727-612-3343

Authorization for Release of Information

Authorization for: _____ Release of Information _____ Request for Information

I, _____ DOB_____ authorize

_____ to disclose to and/or obtain from

_____ the following information.

Dates of Therapy_____

To release/copies of the following confidential information which may include alcohol and substance abuse information which may be protected under Federal Regulations in Code-42 part 2, and/or abstract of information which includes medial, psychiatric and /or psychological, HIV Antibody Testing information.

For the purpose of this discloser of information is to improve assessment and treatment planning, sharing information relevant to treatment and when appropriate coordinate treatment services.
(Client/Patient should initial each item to be disclosed)

I specifically authorize the release of the flowing:

_____Medical History & Physical Exam	_____Admission/Evaluation
_____Progress Notes	_____Psychological Evaluation
_____Consultation Reports	_____Physician Orders
_____Discharge Treatment Summary	_____Educational Information
_____Psychiatric Evaluation	_____Progress in Treatment

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **HOPE In Home Counseling, LLC** . I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this consent expires 90 days from the date of signature. I further understand that **HOPE In Home Counseling, LLC** will not condition my treatment on whether I give authorization for the requested disclosure. I release **HOPE In Home**

Counseling, LLC from any liability which may arise as a result of the use if the information contained hereby released. It is presumed that if such information is later used to my damage it was obtained as a result of this authorization.

I will be given a copy of this authorization for my records.

Signature of Client/Patient Date

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc….).

Witness Signature_____Date_____