Joy Counseling and Consulting, LLC
17505 N 79th Ave Suite 213-D Glendale, AZ 85306 623-313-0111 joycounselingandconsulting.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____ (Date of Birth) _____ authorize Joy Counseling and Consulting, LLC / Joy Giorgio, LMFT to:

_____ release to:
_____ obtain from:
_____ exchange with:
Name: _____Rel:_____
Address: _____
_____
Telephone: _____ FAX: _____

the following information pertaining to myself:

_____ all pertinent records
_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ progress notes
_____ other (specify) _____

for the purpose of:

_____ collateral information
_____ consultation
_____ legal issues
_____ health benefit utilization
_____ evaluation/assessment
_____ coordinating treatment
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____
_____. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is confidential with exceptions pertaining to matters of danger to self or others, and to assault or neglect of children, elders or dependent persons. *Please note that Arizona Revised Statutes relating to Disclosure with Client's Consent can be found at Title 42, Chapter 1, Part 2, Federal register, volume 40, number 127

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ _____
Signature of Client Date Signature of Witness Date

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RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:

_____ 6 months OR
_____ other (specify) _____

_____ _____
Signature of Client Date Signature of Witness Date