

Joy Counseling and Consulting, LLC

21448 N. 75th Ave Suite#11 Glendale, AZ 85308 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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