Date of Consent:

Date Expires:

Essential Connections

COUNSELING & CONSULTING

12700 Century Drive, Unit E, Alpharetta, GA 30009

Info@essentialconnections.net | www.essentialconnections.net

804-627-2365 (direct) | 470-253-1362 (fax)

Release of Information
Authorization to Release/Receive

(please mark all applicable items)

1. I am completing this form to allow the use and sharing of protected health information about:

_____ _____/_____/_____ _____

Client's Full Name Date of Birth Phone

2. I authorize Lisa Reid, LCSW, Psychotherapist of Essential Connections, LLC

3. To obtain, disclose and discuss the following information (check all that apply:

	Clinical mental health information for the sole purpose of enhancing treatment outcomes relating to mental health		Dates of scheduled appointments and attendance (+/-) at each
	Invoices, billing with dates of service, diagnosis and payment information only		Medical reports or other documents with diagnoses, prognoses, recommendations
	Psychological/psychiatric reports, assessments, evaluations, behavioral observations or checklists, diagnoses, prognoses, recommendations		Academic & educational records, including achievement and other test results, reports of teachers' observations & all other school or special education documents
	Summaries of progress or other documents with diagnoses, prognoses, recommendations		Other or limitations:

4. ❒ To the following person or organization: (see below)

❒ From the following person or organization: (see below)

Name/Organization: _____

Address: _____

_____

Phone Number: (_____)_____-_____

Fax Number: (_____)_____-_____

Client's Relationship to this Person: _____

Client Name: _____
Date Consent Begins: _____

5. This release shall permit my psychotherapist, Lisa Reid, LCSW, to speak directly or in writing to the third party or organization named in Paragraph 4 concerning my care as provided in Paragraph 3 of this Authorization.

6. The information will be used/ disclosed for the following purposes:

   ❒ at the request of the individual client, or
   ❒ other _____

7. I understand and agree that this Authorization will be valid:

   ❒ One calendar year from today or
   ❒ Until _____/_____/ 20_____ (date upon which this Authorization expires).

   I understand that after the date indicated, no more of this information can be used or released to the person or organization unless I sign a new Authorization.

8. I understand that I can revoke or cancel this Authorization at any time by sending a letter to Essential Connections, LLC, 12700 Century Drive, Unit E, Alpharetta, GA 30009. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

9. I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

10. I understand that information used or disclosed pursuant to the Authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

My signature below represents my understanding and agreement to the Authorizations as indicated.

_____	_____	____/_____/_____
Signature of Client	Printed Name of Client	Date
_____	_____	____/_____/_____
(1) Signature of Client's Legal Representative	(1) Printed Name of Client's Legal Representative ❒ Parent ❒ Legal Guardian ❒ Other	Date
_____	_____	____/_____/_____
(2) Signature of Client's Legal Representative	(2) Printed Name of Client's Legal Representative ❒ Parent ❒ Legal Guardian ❒ Other	Date
_____	_____	____/_____/_____
Signature of Therapist/Witness	Printed Name of Therapist/Witness	Date