Healing Waters Counseling Center, LLC

P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

Clinical Director: Bradley T. Kinder, M.S., LPC, CSAC
Licensed Professional Counselor, Certified Substance Abuse Counselor

Authorization for Disclosure/Exchange of Information

Client Name		DOB		SSN	

I hereby authorize Healing Waters Counseling Services, LLC and _____, at
Person or Agency--one per page
_____ to exchange information.
Telephone/Address

The type of information to be disclosed:

☐ **Evaluations** [including Diagnostic Interviews and/or Psychological Evaluations]
☐ **Diagnoses**
☐ **Treatment Plan**
☐ **Psychological Test Results**
☐ **Substance Abuse Records/Treatment**
☐ **Course of Treatment** [including progress notes]
☐ **Other** _____

The purpose of such disclosure:

☐**Ongoing Treatment** ☐**Transfer** ☐**Legal Issues**
☐**Evaluation** ☐**Coordination of Care** ☐**Other**

Exceptions: _____

The designated information about me ☐**may** ☐**may not** be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Healing Waters Counseling Center, LLC and the above designated person ☐**may** ☐**may not** discuss by telephone the content of the information released.

This consent is in effect until _____, or for **one year if not specified**. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

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 legally confidential, except as provided in § 32.1-127.1:03 of the Virginia State Code and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

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.

_____ _____
Date Signature of Client (13 or older)

_____ _____
Date Signature of Parent/Guardian/Authorized Representative

_____ _____
Date Witness