



Healing Waters Counseling Center, LLC

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

Authorization for Disclosure/Exchange of Information

Table with 5 columns: Client Name, DOB, SSN, and two empty columns.

I hereby authorize Healing Waters Counseling Services, LLC and _____, at
(Person or Agency – one per page)

Telephone/Address

to exchange information. The type of information to be disclosed:

- Checkboxes for Evaluations, Diagnoses, Treatment Plan, Psychological Test Results, Substance Abuse Records/Treatment, Course of Treatment, and Other.

The purpose of such disclosure:

- Checkboxes for Ongoing Treatment, Evaluation, Transfer, Coordination of Care, Legal Issues, and 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