



Authorization for Disclosure/Exchange of Information

Client's Full Legal 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 _____ Medical/Hospital Records _____
- Diagnosis _____ Psychological/Medical Test Results _____
- Treatment Plan _____ Mental Health Record Summary _____
- Course of Treatment _____ Psychotherapy Notes _____
- Other _____ Substance Abuse Records/Treatment _____

The purpose of such disclosure:

- Ongoing Treatment _____ Medical Care _____ Consultation _____
- Evaluation _____ Transfer _____ Legal Issues _____
- Coordination of Care _____ Health Benefit Utilization _____ 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