Joy Counseling and Consulting, LLC
21448 N 75th Ave Suite #6 Glendale, AZ 85306 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 legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS 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.

_____ _____
Signature of Client Date Signature of Witness Date

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RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:

_____ 6 months OR
_____ other (specify) _____

_____ _____

Signature of Client Date Signature of Witness Date