Initial Each Page Here: __________

T R U T H E R A P Y

RELEASE OF INFORMATION

Client's Full Name: ____

Client's Date of Birth: ____

Authorization initiated by:

☐ Client
☐ Parent
☐ Legal Guardian
☐ Representative of Deceased
☐ Other ____

I hereby authorize TruTherapy LPC to ☐ **release /** ☐ **receive** my confidential protected health information to the person or facility below.

Full name of person/facility: ____
Phone: ____
Fax: ____
Address: ____
Relationship to Client: ____

Type of Information to be disclosed:

☐ My Entire Medical Record
OR
☐ Evaluations/Assessments
☐ Psychotherapy Notes
☐ Treatment Plan
☐ Discharge Summary
☐ Treatment Summary
☐ Alcohol and Drug Treatment
☐ Appointments and Scheduling
☐ Billing Records
☐ Other ____

The purpose of such disclosure:

☐ At the Request of the Client
☐ Coordination of Care
☐ Consultation

Initial Each Page Here: __________

☐ Evaluation
☐ Transfer
☐ Legal Issues
☐ Disability Determination
☐ Other ____

I understand that I can revoke or cancel this Authorization at any time by sending a letter to TruTherapy LPC in-person, faxed to (706) 843-6242, or mailed to PO BOX 7660 North Augusta, SC 29861. 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. I understand that information used or disclosed pursuant to the Authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

____
Signature of Client

____
Signature of Legal Guardian if Client is a Minor

____
Printed Name of Legal Guardian if Client is a Minor

____
Date

**********TO BE COMPLETED BY TRUTHERAPY PERSONNEL ONLY **************

Date revocation of authorization was received: ____

____
Name of TruTherapy Personnel

____________________________________ ______________________
Signature of TruTherapy Personnel Date