HOLY FAMILY COUNSELING CENTER
4411 Suwanee Dam Rd, Suite 720
Suwanee, GA 30024 | (678) 993-8494

REQUEST FOR RELEASE/EXCHANGE OF CLIENT INFORMATION WHEN SESSIONS ARE PAID FOR BY A THIRD PARTY

I (We)______________________________________ **HEREBY AUTHORIZE** ______________________________________

(*Client Name*) (*Requesting Counselor Name*)

to release/exchange information contained in my client records to the following individual(s) and/or organization

____.

(*Name and phone number of person to be contacted*)

The type of information to be released might include records or information concerning attendance, treatment plan, clinical assessment, psychological history, goals and progress, prognosis, or other information pertinent to the successful treatment of said client. The purpose for such disclosure/exchange might include continuity of treatment, family involvement, community support, aftercare planning, and/or consultation with other staff therapists or referral.

Please initial below next to the information Holy Family Counseling Center can share with the Third Party Provider referenced above in this document.

_____ Holy Family Counseling Center may send a bill to the provider referenced above which indicates information required by insurance companies to include the date of the session, the diagnostic code, the type of therapy and which therapist from Holy Family Counseling Center that I am seeing.

_____ Holy Family Counseling Center may give a brief update to the Third Party Provider referenced above on my progress.

I hereby release ______________________________________ from any and all liabilities, responsibilities, damages and claims

(*Requesting Counselor's Name*)

which might arise from the release of the information authorized above. I understand that information may be transmitted by electronic means such as FAX, email and/or U.S. postal service. Portions of the information provided may not pertain exclusively to my current diagnosis. I also understand that I may revoke this consent at any time or that it expires automatically as described below.

Date, Event, or Condition of expiration: ____

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

____________________________________ ____________________________________

(*Signature of Client*) (*Signature of Witness*)

____________________________________ ________________ _____________

(*Parent, Guardian, or Authorized Representative*) (*Relationship to Client*) (*Date*)