Authorization for Release of Information

I, ____________________________________, whose Date of Birth is ________________, authorize *Transpersonal Mental Health Counseling Services, PLLC* to disclose and/or obtain from___________________________________,

the following information:

____ whether or not client is in mental health treatment
____ dates of appointments
____ attendance and participation
____ mental health diagnosis
____ summary of treatment progress
____ all of the above

Purpose
This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify:

____

Expiration
Unless sooner revoked, this authorization expires one year after this date, or one year after my last scheduled session.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by filling out and signing the "Cancellation to Release of Information" below. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

____
Signature of Client Date

____
Signature of Witness Date

Cancellation to Release of Information
I hereby cancel my permission to release information indicated above.

____
Signature of Client Date

<u>For Office Use Only</u>
____ Client refused to sign Release of Information

____
Therapist Signature Date