**INSPIRING HEALING AND HOPE COUNSELING AND DEVELOPMENT CENTER, LLC**

**44 Darby’s Crossing Drive Suite 202**

**Hiram, GA 30141**

**404-907-6635**

**RELEASE OF INFORMATION**

I, , do hereby authorize or

any related representative at Inspiring Healing and Hope Counseling and Development Center, LLC to

 release  receive  exchange

information concerning \_ (Name of Client, DOB)

 to  from  with

I understand that such disclosure will be made for the following purposes:

|  |  |  |
| --- | --- | --- |
| Treatment Progress |  Psychiatric Evaluation |  Child Custody / Visitation |
|  Treatment Planning |  Social History |  Competency to stand trial |
|  Medical Treatment |  Treatment Summary |  Other |

 Reimbursement for Treatment  Diagnosis

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by giving written notice to LaShawn Faison-Bradley, LPC

If no prior notice of revocation is received, this consent will expire automatically two (2) years after the date indicated thereon.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I have read, or had read to me, the above, and understand the contents.

I authorize this information to be faxed to the party indicated above, and

Initial understand the limits of confidentiality which doing so creates.

I have received and read the ROI, however at this time, I do not have anyone I wish to release

Initial information to. I am aware that I can make additions/changes as necessary and at anytime by completing this form.

Signature of client, parent, or legal guardian Date