# Authorization Form to Obtain/Release of Confidential Information

Client Name_____ Date of Birth _____

This completed and signed form authorizes me to release protected information from your clinical record to the person/agency you designate.

I authorize my psychologist, Fresh Start for the Mind, LLC, to obtain/release the following:

- □ Pertinent treatment information
- □ Copy of treatment records
- □ Diagnosis and/or prognosis
- □ Results of psychological evaluation
- □ Treatment attendance/compliance
- □ Verbal communication
- □ Other (be as specific and detailed as possible, and include any limitations):

_____
_____

The disclosure of information is required for the following purpose(s):

- □ Coordination of treatment
- □ Referral to/from
- □ Collateral contact for evaluation purposes
- □ Other: _____

This information should only be obtained from/released to the following: (Provide name, institutional affiliation and address of person from/to whom the information is to be obtained/released):

Name/Agency: _____
Address: _____
_____
Phone: _____ ____

Notice

Fresh Start for the Mind, LLC is required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information (no longer protected by the HIPAA Privacy Rule).

My Rights

I may revoke this Authorization at any time, provided that I do so in writing and submit it to Fresh Start for the Mind, LLC, 5400 Laurel Springs Parkway, Ste. 802, Suwanee, GA 30024. However, my Authorization will not be effective to the extent that Fresh Start for the Mind, LLC has taken action in reliance on my Authorization, or if this Authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim. I understand that Fresh Start for the Mind, LLC generally may not condition psychological services upon my signing an authorization unless the psychological services are provided for me for the purpose of creating health information for a third party.

Expiration of Authorization

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

**Signature**

_____ _____
(Signature of Client, Parent/Guardian, Legal Representative) Date

_____
Printed Name

_____
Witness