Humanistic Counseling Center

Post Office Box 24242, Cleveland, Ohio 44124-0242
www.HumanisiticCounselingCenter.com
Fax 216-896-0735
Phone 216-839-CARE (2273)

To: ______________________________ Date:____________________
Name
____
Address
____
Address
____
Telephone

From: ______________________________ Phone:____________________

Concerning: ______________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ The staff of Humanistic Counseling Center have permission to provide information concerning my diagnosis, testing, and treatment to the organization or individual named above.
_____ The individual or organization named above has my permission to provide information to the staff of Humanistic Counseling Center and its management.
_____ The professionals above have permission to discuss my care.

_____ Other ______________________________

______________________________ ______________________________
Signature of Client Date

I expressly consent to the release of the information designated above. I understand and acknowledge that the purpose for this is to promote continuity of care and collaboration between the therapist and other professionals, organizations, and/or health care providers through the communication of the referral, diagnostic, treatment records and/or other information listed above. I understand that communication between the therapist and the party designated above may be verbal or in writing or both in order to exchange only the information specified above and will be handled in a confidential manner by the parties.

I understand that my records are protected under the applicable state laws governing health care information that relates to mental health services and under Federal regulation codes for Confidentiality of Drug & Alcohol Records, Title 42 CFR Part 2, and that this information cannot be re-disclosed by anyone without my written consent unless otherwise provided for in state or Federal regulations.

This authorization may be revoked at any time by the client or their legal guardian by submitting the request in writing to the therapist. I understand that any information released prior to revocation cannot be retrieved and that the therapist will not be held responsible for such. I hereby release the therapist from all legal responsibilities or liability that may arise from this act. This authorization automatically becomes invalid one year from the dated signed.

I would appreciate
_____ your sending me the information requested at the address above.
_____ your faxing the information to 216-896-0735.
_____ your emailing me at ______________________________
_____ your calling me at ____________________ to discuss this client's care
_____ other ______________________________

REV 7/12/21

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Signature of Therapist