Client Name: _____

Authorization for Release of Information and Records

To: Counseling Center at Heritage, LLC

I, _____, have been informed that under Pennsylvania state law and federal HIPPA requirements communications between a patient and his/her psychotherapist are privileged and may not be disclosed by the mental health provider unless the patient consents. I also have been informed that patient records required by a mental health provider may not be disclosed to third parties except with the patient's consent or through legal process.

I hereby authorize the Counseling Center at Heritage, LLC to disclose, release, and /or obtain records to or from the following:

[] My primary care physician, Dr._____ At office_____

[] My family members as listed _____

[] My lawyer _____

[] The person who referred me _____

[] My previous therapist _____

[] Other _____

Purpose

This authorization is only for the limited purpose of releasing information and discussing my case with these individuals or companies for the listed purposes including but not limited to: evaluation, treatment planning, and/or as requested on my behalf.

Revocation

I have the right to revoke this authorization at any time by sending written notification to The Counseling Center at Heritage, LLC. I further understand that the revocation of this authorization is not effective to any actions have previously been taken in reliance on this authorization; it is effective on future communications.

Form of Disclosure

Unless I have specifically requested, in writing, that the disclosure is to be made in a certain format, The Counseling Center at Heritage, LLC reserves the right to disclose the information in any manner we deem to be appropriate and consistent with applicable laws, including: verbally, paper, or electronically.

Signature_____ Date_____

Witnessed by _____ Date _____