

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: \_\_\_\_\_