AUTHORIZATION FOR RELEASE OF INFORMATION

HEALING MIND SPACE

194 Waterman Street Suite 1
Providence, RI 02906

(401) 484-0244

I,_______________________________________, hereby authorize Healing Mind Space (HMS) and Name of person/hospital/agency/ company:____Address:_ ____ __________ Telephone: _______________________________ Fax: ________________________________ to exchange information, regarding the treatment of_______________________________, whose date of birth is ___________________.

The type of information to be disclosed:

○ *Evaluations*
○ *Medical/Hospital*
○ *School Records*
○ *Psychological/Medical*

The purpose of disclosure:

○ Ongoing Treatment ○ Legal Issues
○ Evaluation

The designated information ○ ***may***
transfer mechanisms. HMS and the above designated person ○ ***may***
○ ***may not*** discuss by telephone the content of the information released.

This consent is in effect until ______________________. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original. I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed professional counselors, except for matters of danger to self or others, assault or neglect of a child or elder.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

____

_________________________ Signature of Client or Personal Representative Date