In the Garden COUNSELING

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

Name: ____ DOB: ____________________

I hereby authorize In The Garden Counseling and ____
to share specified information in my client record.

This data shall include the following information:

Psychological Evaluation, Psychiatric Evaluation, Progress Notes, Intake Assessment/Comprehensive Clinical/Diagnostic Assessment, Diagnosis, Treatment Plan, Medical Information, IEP/School Information.

Other Pertinent Information requested: ____

This information will be used for service delivery, continuity of care, referral information and other as listed below.
Other ____________________

I hereby acknowledge that the staff at In The Garden Counseling has not conditioned my treatment on signing this authorization and that I may refuse to sign this authorization if I so desire. I also recognize that I retain the right to revoke this authorization except to the extent that has already taken action in reliance on the consent. Request for revocation should be submitted directly to Johannah Robinette. Once information is disclosed pursuant to this signed authorization, I understand that the HIPAA privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information, and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (G.S. 122-C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), this organization informs the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

If not revoked earlier, this authorization expires automatically one year from the date it is signed.

I HAVE READ THIS INFORMATION AND UNDERSTAND THAT THERE ARE STATUTES AND REGULATIONS PROTECTING THE CONFIDENTIALITY OF UNAUTHORIZED INFORMATION. I HEREBY ACKNOWLEDGE THAT THIS AUTHORIZATION IS TRULY VOLUNTARY AND THAT I AM THE PROTECTED CONSUMER OR AM AUTHORIZED TO ACT ON BEHALF OF THE CONSUMER, TO SIGN THIS DOCUMENT. I FULLY AGREE WITH THE ABOVE STATED TERMS. I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS AUTHORIZATION ONCE IT HAS BEEN SIGNED.

__________________________ Consumer   ________________ Date   or   __________________________ Legally Responsible Person   ________________ Date

__________________________ Witness   ________________ Date

704.928.7360

inthegardencounseling.com

Johannah Robinette
Licensed Professional
Counselor, MAEdS, LPC, NCC