Authorization to Release Mental Health Care Information

Hillside Counseling Center
4474 Towne Lake Parkway
Woodstock, GA 30189
770.924.8517

_____
(Patient's Name)

_____
(Date of Birth)

_____
(Address)

_____ _____
(Phone) (Email)

I request and authorize the mutual release of health care information of the patient named above between the following Hillside Counseling center therapist (indicated by my initials):

Please initial	Therapist	Best contact phone number
_____	Carol Zepf, M.S., Ed.S., LPC	770.924.8517, ext. 121
_____	Allison Spargo, Ph.D,LPC	770.924.8517, ext. 263

. . . and . . .

_____
(Name of Facility or Practice)

_____
(Address of Facility or Practice)

_____

_____
(Phone Number/Fax Number)

This request and authorization applies to:

- _____ Health care information relating to the following treatment, condition or dates of treatment:

  _____
- _____ All health care information
- _____ Other: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER THE DATE IT IS SIGNED AND MAY BE REVOKED AT ANY TIME UPON WRITTEN REQUEST OF THE CLIENT EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN.

_____ _____
Signature of patient or patient's authorized representative Date signed

_____
Relationship or status if signed by anyone other than patient (parents, etc.)