Authorization to Release
Mental Health Care Information

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www.hillsidecounselingcenter.com

Hillside
COUNSELING CENTER

Date of birth: _____

Your Name: _____
Last First Middle Initial

Home Address: _____

City: _____ State: _____ Zip: _____

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: _____

City: _____ State: _____ Zip: _____

Phone Number / Fax Number: _____

This request and authorization applies to:

_____ Healthcare information relating to the following treatment, condition or dates of treatment:

_____

_____ All heath 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 ANYTIME 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 lf signed by anyone other than patient (parents, etc.)