I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize International Community Hope Project LLC and

Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to exchange information.

Name Telephone

The type of information to be disclosed:

Evaluations \_\_\_\_\_ Medical/Hospital Records\_\_\_\_\_

Diagnosis \_\_\_\_\_ Psychological/Medical Test Results\_\_\_\_\_

Treatment Plan\_\_\_\_\_ Mental Health Record Summary\_\_\_\_\_

Course of Treatment\_\_\_\_\_ Psychotherapy Notes \_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of such disclosure:

Ongoing Treatment\_\_\_\_\_ Medical Care\_\_\_\_\_ Consultation\_\_\_\_\_

Evaluation\_\_\_\_\_ Transfer\_\_\_\_\_ Legal issues\_\_\_\_\_

Coordination of Care\_\_\_\_\_ Health Benefit Utilization\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_

Exceptions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The designated information about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms.

International Community Hope Project LLC 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 take 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 client communications in therapy are protected under federal and state confidentiality

regulations and cannot be disclosed without client/guardian written authorization.

The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

Page 2

This authorization to disclose private health information is for the release of psychotherapy notes or

purposes other than my treatment, payment or the related operations of the practice, and I understand

that my authorization, or refusal, will not affect my ability to get treatment or payment. However, the

Practitioner can condition those things (1) if the my treatment is related to research, or (2) if my

treatment is being provided to me solely for the purpose of creating protected health information for

disclosure to a third party.

By my signature below, I acknowledge a receipt of this disclosure.

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client or Personal Representative**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client or Personal Representative**

*Note: This form may be used for a release of information when HIPAA compliancy is not required but*

*our practice standards are to obtain a written release, by using page one only. The second page*

 *(which can be the backside of the first page) makes this a HIPAA compliant authorization for use*

*when the release is to 3rd parties and is not related to treatment, payment, or operations activities.*

*Since psychotherapy notes are so sensitive and enjoy extra protection under HIPAA, it is advisable to*

*use the following form for authorization to release psychotherapy notes. Remember, they must have a*

*separate authorization form, and cannot be included on authorizations to release other information.*