Thrive Counseling & Trauma Therapy HIPAA Release of Information Form

Authorization For Release of Information

I, _____, hereby authorize Thrive Trauma, Inc. and
(Client)

_____ to exchange information.
(Name of Individual/Practice/Institution)

The type of information to be disclosed:
☐All Records and Information _____
OR (Initial)

☐ Medical/Hospital Records	☐ Diagnosis	☐ Evaluations
☐ Psychological/Medical Test Results	☐ Treatment Plan	☐ Psychotherapy Notes
☐ Mental Health Record Summary	☐ Course of Treatment	☐ Content of Sessions
☐ Progress	☐ Treatment History	

☐ 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 me ☐ may ☐ may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Thrive Trauma Inc. and the above designated person/practice/institution ☐ may ☐ may not discuss by telephone the content of the information released.

This consent is in effect until for one year unless revoked. 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 my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization.

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.

Signed _____ on _____
Signature of Client Date

Witnessed _____ on _____
Signature Date