THRIVE
Counseling & Consultation, LLC
Tampa, FL
www.thriveflorida.com

RELEASE OF INFORMATION

Authorization for Disclosure of Mental Health Treatment Information

I, _____[Name of Patient/Client], whose Date of Birth is _____, authorize Thrive Counseling & Consultation, LLC to disclose to and/or obtain from the following person/ organization, _____, the following information:

Description of Information to be Disclosed

(Please initial each item to be disclosed)

_____ Assessment

_____ Diagnosis

_____ Treatment Plan or Summary

_____ Current Treatment Update

_____ Attendance/Participation in Treatment

_____ Discharge/Transfer Summary

_____ Progress in Treatment

_____ Demographic Information

_____Psychotherapy Notes*

_____Other_____

Purpose of Disclosure

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify:

_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbal, written, or electronic.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

_____

Signature of Witnessing Staff Date