Forever Hope Counseling & Educational Services, LLC

Stone Oak Location
1162 E Sonterra Blvd Suite 130
San Antonio, Texas 78258

Alamo Heights Location
4900 Broadway Suite 500
San Antonio, TX 78209

www.foreverhopecounseling.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client's Name: _____
First Middle Initial Last

Date of birth: _____

Date authorization initiated: _____

Authorization initiated by: _____
(Name of client, parent/guardian, provider, or other)

Information to be released:

☐ Authorization for Psychotherapy Notes **ONLY**
(Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

☐ Other (Describe information in detail): _____

Purpose of Disclosure:
The reason I am authorizing release is:

☐ My request

☐ Other (describe): COLLABORATE SERVICES

Person(s) Authorized to Make the Disclosure: FOREVER HOPE COUNSELING

Person(s) Authorized to Receive the Disclosure: _____

This authorization will expire on _____-_____ or upon the happening of the following event: UNTIL REVOKED

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____
Signature of client/Parent or Guardian Date

_____ _____
Printed name of client/Parent or Guardian Date

_____ _____
FHC Office Staff/Clinician Date